California Association of Health and Education Linked Professions
Joint Powers Authority (CAHELP JPA)
DESERT/MOUNTAIN CHARTER SELPA EXECUTIVE COUNCIL MEETING
October 21, 2021 – 10:00 a.m.
Desert Mountain Educational Service Center, 17800 Highway 18, Apple Valley CA 92307

AGENDA

NOTICE: This meeting will be held as a hybrid council meeting with some council members participating in person and others participating via Web Ex. If members of the public wish to participate in the meeting and/or make public comment, please follow the instructions below to participate telephonically:

PARTICIPATE BY PHONE:
Dial Access Number: 1-415-655-0003
When prompted - enter Meeting Number: 2464 778 0269
Follow directions as a Participant; an Attendee I.D. is not required to participate.

If you wish to make a public comment at this meeting, prior to the meeting please submit a request to address the D/M Charter SELPA Executive Council to the recording secretary via fax at 1-760-242-5363 or email jamie.adkins@cahelp.org. Please include your name, contact information and which item you want to address.

Reasonable Accommodation: If you wish to request reasonable accommodation to participate in the meeting telephonically, please contact the recording secretary (via contact information noted above) at least 48 hours prior to the meeting.

1.0 CALL TO ORDER

2.0 PUBLIC PARTICIPATION

Citizens are encouraged to participate in the deliberation of the Desert/Mountain Charter SELPA Executive Council. Several opportunities are available during the meeting for the Council to receive oral communication regarding the presentations of any items listed on the agenda. Please ask for recognition either before a presentation or after the presentation has been completed. Please complete and submit a "Registration Card to Address the Desert/Mountain Charter SELPA Executive Council" to the Recording Secretary and adhere to the provisions described therein.

3.0 ROLL CALL

4.0 ADOPTION OF THE AGENDA

4.1 **BE IT RESOLVED** that the October 21, 2021 Desert/Mountain Charter SELPA Executive Council Meeting Agenda be approved as presented.

5.0 INFORMATION/ACTION

5.1 Desert/Mountain Charter SELPA D/M 66 Assessment Plan (**ACTION)**

Forms used in the operations of special education programs within the Desert/Mountain Charter SELPA are developed, reviewed and revised throughout the year upon the recommendation of the Program Team. Forms are modified as necessary in order to support the operations of special education programs in an efficient, effective and legally compliant manner. Suggested revisions to

AGENDA

SELPA Forms are submitted to the D/M Charter SELPA Steering Committee for consideration and approval.

5.1.1 **BE IT RESOLVED** that the Desert/Mountain Charter SELPA D/M 66 Assessment Plan be approved as presented.

5.2 Desert/Mountain Charter SELPA Policy and Procedures Chapter 1 **(ACTION)**

Policies and procedures governing the operation of special education programs within the Desert/Mountain Charter SELPA are developed, reviewed and revised throughout the year upon the recommendation of the Program Team. Policies and Procedures are modified as necessary in order to ensure that special education programs are operated in an efficient, effective and legally compliant manner. Suggested revisions to Charter SELPA Policy and Procedures are submitted to the D/M Charter SELPA Steering Committee for consideration and approval.

5.2.1 **BE IT RESOLVED** that the Desert/Mountain Charter SELPA Policy & Procedures Chapter 1 be approved as presented.

5.3 Desert/Mountain Charter SELPA Interim Placement Form (**ACTION)**

Forms used in the operations of special education programs within the Desert/Mountain SELPA are developed, reviewed and revised throughout the year upon the recommendation of the Program Team. Forms are modified as necessary in order to support the operations of special education programs in an efficient, effective and legally compliant manner. Suggested revisions to SELPA Forms are submitted to the D/M SELPA Steering Committee for consideration and approval.

5.3.1 **BE IT RESOLVED** that the Desert/Mountain Charter SELPA Interim Placement Form be approved as presented.

5.4 Desert/Mountain Children's Center Electronic Health Record Policy (**ACTION)**

Policies and procedures governing the operation of special education programs within the Desert/Mountain SELPA are developed, reviewed and revised throughout the year upon the recommendation of the Program Team. Policies and Procedures are modified as necessary in order to ensure that special education programs are operated in an efficient, effective and legally compliant manner. Suggested revisions to SELPA Policy and Procedures are submitted to the D/M Charter SELPA Steering Committee consideration and approval.

5.4.1 **BE IT RESOLVED** that the Desert/Mountain Children's Center Electronic Health Record Policy be approved as presented.

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6.0 CONSENT ITEMS

It is recommended that the Desert/Mountain Charter SELPA Executive Council consider approving several Agenda items as a Consent list. Consent Items are routine in nature and can be enacted in one motion without further discussion. Consent items may be called up by any Committee Member at the meeting for clarification, discussion, or change.

6.1 **BE IT RESOLVED** that the following Consent Items be approved as presented:

6.1.1 Approve the April 15, 2021 Desert/Mountain Charter SELPA Executive Council Meeting Minutes.

7.0 CHIEF EXECUTIVE OFFICER AND STAFF REPORTS

7.1 Legislative Updates

Jenae Holtz will present the latest in State and Federal law related to students with disabilities and school law.

7.2 2021-22 Risk Pool Levels

Jenae Holtz will provide information on the 2021-22 Risk Pool Levels.

7.3 Desert/Mountain Charter SELPA Policy and Procedure Chapter 14 Appendix B

Jenae Holtz will present the updated D/M Charter SELPA Policy and Procedure Chapter 14 Appendix B Non-Exclusive List of Qualified Examiners.

7.4 Professional Learning Summary

Heidi Chavez will present an update on the SELPA's professional development.

7.5 Resolution Support Services Summary

Kathleen Peters will present an update on the SELPA's resolution support services.

7.6 Compliance Updates

Peggy Dunn will present compliance updates.

8.0 FINANCE COMMITTEE REPORTS

9.0 INFORMATION ITEMS

AGENDA

10.0 DESERT/MOUNTAIN CHARTER SELPA EXECUTIVE COUNCIL MEMBERS COMMENTS / REPORTS

11.0 CEO COMMENTS

12.0 MATTERS BROUGHT BY CITIZENS

This is the time during the agenda when the Desert/Mountain Charter SELPA Executive Council is again prepared to receive the comments of the public regarding items on this agenda or any school related special education issue.

When coming to the podium, citizens are requested to give their name and limit their remarks to three minutes.

Persons wishing to make complaints against Desert/Mountain Charter SELPA Executive Council personnel must have filed an appropriate complaint form prior to the meeting.

When the Desert/Mountain Charter SELPA Executive Council goes into Closed Session, there will be no further opportunity for citizens to address the Council on items under consideration.

13.0 ADJOURNMENT

The next regular meeting of the Desert/Mountain Charter SELPA Executive Council will be held on Thursday, January 7, 2022, at 10:00 a.m., at the Desert Mountain Educational Service Center, Aster/Cactus Room, 17800 Highway 18, Apple Valley, CA 92307.

Individuals requiring special accommodations for disabilities are requested to contact Jamie Adkins at (760) 955-3555, at least seven days prior to the date of this meeting.

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307
(760) 552-6700 • (760) 242-5363 FAX

Assessment Plan

If an assessment for the development or revision of the Individualized Education Program is to be conducted, the parent or guardian of the student shall be **given** [by the Local Educational Agency (LEA)], in writing, a proposed assessment plan within 15 days of the referral for assessment not counting days between the student's regular school sessions or terms or days of school vacation in excess of five school days from the date of receipt of the referral, unless the parent or guardian agrees, in writing, to an extension. CA Ed Code § 56321(a)

STUDENT INFORMATION

Student Name:		Date of Birth:		Grade:	
School Site:		District or LEA of Residence:			

English Language Proficiency: ☐ English Language Learner ☐ Fluent English Proficient ☐ English Only ☐ Language spoken at home:

This notice is to inform the parent(s)/guardian(s) regarding the school district's/LEA's proposal to initiate or change the: ☐ Identification ☐ Evaluation of the above-named student:

This prior written notice includes a description of the proposed evaluation, an explanation of why the district or Local Educational Agency (LEA) proposed to take this action, a description of any other options that were considered and the reasons why those options were rejected, and other factors that are relevant to this proposal. Your written permission must be given before we assess your child to determine initial or continued eligibility for special education services. You have the right to be familiar with the assessment procedures and type of tests that may be given to your child. After the assessment is completed, you will be notified in writing of a meeting to discuss the results of the evaluation. If your child is found eligible for special education services, a full range of program options will be discussed.

Description of the proposed assessment:

The assessment will be conducted by qualified staff, and when appropriate, interpreters of the individual's primary language may be used. Tests conducted pursuant to these assessments may include, but are not limited to classroom observations, rating scales, one-on-one testing or some other types or combination of tests. No single procedure may be used as the sole criterion for determining an appropriate educational program. Following the completion of the assessment at the IEP meeting, you will receive a copy of the assessment findings. The results of the assessment may be a recommendation for special education services or maintenance or change of the current special education service(s). A student will not be placed in special education without consent of the parent or guardian. All information and assessment results are confidential.

Reason(s) for proposed assessment:

Description of other options considered and reasons for rejecting them: *(List other courses of action the LEA considered for student's educational program, including but not limited to consideration of information/requests from parent and data/screening/observation by LEA personnel, OR actions that were requested on behalf of Student; AND, explain the reasons the LEA refused these courses of action.)*

Other factors relevant to the proposal:

Description of evaluation procedures, tests, records, or reports used in deciding to propose this assessment:

The district proposes to assess your child to determine his/her eligibility for special education services or continued eligibility and present levels of academic performance and functional achievement to determine services. Your child will be assessed in all areas of suspected disability as needed.* To meet your child's individual education needs, this assessment will consist of an evaluation in only the areas checked by the local educational agency (LEA)/district. **Tests conducted pursuant to these assessments may include, but are not limited to classroom observations, rating scales, one-on-one testing or some other types or combination of tests.*

Student Name:		Date of Birth:		Grade:	

ASSESSMENT INFORMATION

Reason(s) for referral/assessment: ☐ *Initial* ☐ *Annual* ☐ *Triennial* ☐ *Behavior* ☐ *Counseling/Behavioral Health Services* ☐ *Other:*

Referred by: ☐ *Parent/Guardian* ☐ *Teacher* ☐ *Special Ed. Teacher* ☐ *Psychologist* ☐ *Nurse* ☐ *Administrator* ☐ *IEP Team* ☐ *Other:*

The assessment will be administered in: ☐ *English* ☐ *Spanish* ☐ *Braille* ☐ *Sign Language* ☐ *Other:*

ASSESSMENTS CHECKED BELOW WILL BE COMPLETED TO ADDRESS THE AREAS OF SUSPECTED DISABILITY	TO BE COMPLETED BY (*Examiner Title*)
☐ **ACADEMIC/PRE-ACADEMIC ACHIEVEMENT:** These tests measure current readiness skills or achievement levels in reading, spelling, arithmetic, oral and written language skills, and /or general knowledge.	☐ District ☐ County ☐ NPA ☐ Other
☐ **AUGMENTATIVE/ALTERNATIVE COMMUNICATION (AAC)** ☐ **ASSISTIVE TECHNOLOGY (AT):** An assessment to measure the need for any aid and/or device that can be used to increase, maintain, or improve functional capabilities of a student with a disability.	☐ District ☐ County ☐ NPA ☐ Other
☐ **CAREER AND VOCATIONAL DEVELOPMENT:** These tests allow a student to identify interest areas and aptitudes that assist in setting vocational goals and making career choices.	☐ District ☐ County ☐ NPA ☐ Other
☐ **COGNITIVE/INTELLECTUAL DEVELOPMENT AND LEARNING ABILITY:** These tests measure how well a student thinks, remembers, and solves problems, and evaluates a student's general learning aptitude and/or state of intellectual maturation by measuring performance across a variety of verbal, numerical, and visual-spatial tasks.	☐ District ☐ County ☐ NPA ☐ Other
☐ **FUNCTIONAL BEHAVIORAL ASSESSMENT (FBA):** An assessment to measure and/or identify circumstances and consequences associated with a certain behavior and methods/interventions recommended to address them.	☐ District ☐ County ☐ NPA ☐ Other
☐ **HEALTH/DEVELOPMENTAL/MEDICAL:** These tests measure vision, hearing, current health status, and early childhood development.	☐ District ☐ County ☐ NPA ☐ Other
☐ **OBSERVATIONS/INTERVIEWS:** Includes observations of a student's academic and behavioral functioning in the school and/or natural setting.	☐ District ☐ County ☐ NPA ☐ Other
☐ **PERCEPTUAL/MOTOR DEVELOPMENT** These tests measure coordination, body movements, and small and large muscle activities. Physical fitness, visual, and perceptual skills may also be measured.	☐ District ☐ County ☐ NPA ☐ Other
☐ **POST-SECONDARY TRANSITION:** Age appropriate transition assessments related to training, education, employment and where appropriate independent living skills.	☐ District ☐ County ☐ NPA ☐ Other
☐ **SELF-HELP/ADAPTIVE:** This assessment measures how the student takes care of personal needs at home, school and in the community and will help determine the level of personal development in activities of daily living, socialization, and communication skills.	☐ District ☐ County ☐ NPA ☐ Other
☐ **SOCIAL/EMOTIONAL/BEHAVIORAL DEVELOPMENT:** This assessment measures how the student feels about him/herself, gets along with others, and will help determine adjustment in social, emotional, and behavioral areas.	☐ District ☐ County ☐ NPA ☐ Other
☐ **SPEECH/LANGUAGE/COMMUNICATION DEVELOPMENT:** This assessment measures a student's ability to use and understand language. Areas that may be assessed are articulation, receptive and expressive language, fluency, voice, and/or social/pragmatic use of language.	☐ District ☐ County ☐ NPA ☐ Other

REVIEW OF ANY RECENT ASSESSMENT(S):

OTHER: *(If using alternative means of assessment, explain why and what will be utilized for this assessment.)*

FOR QUESTIONS PLEASE CONTACT THE LEA OFFICE:	Name:	Contact Phone:

PARENT/GUARDIAN/ADULT STUDENT AUTHORIZATION

ASSESSMENT CANNOT BEGIN UNTIL A COPY OF THIS FORM HAS BEEN SIGNED AND DATED BY THE PARENT/GUARDIAN/ADULT STUDENT AND RETURNED TO THE LEA. AT THAT TIME, THE ASSESSMENT TIMELINE WILL BEGIN.

INITIAL HERE	Please initial each *applicable* statement below.
	I understand that no educational placement will result from this evaluation without my written permission.
	I have additional assessments or information that I wish to have considered in determining a free appropriate public education (FAPE).
	I prefer to discuss the assessment plan before I give approval.
	I ***DO NOT*** approve of this assessment plan.

By signing this form below, I acknowledge that I am the educational rights holder for this child OR that I am an adult student holding my own educational rights and hereby authorize/consent to the assessments listed above. I understand that the results of the assessments will be kept confidential and will be reviewed with me. My signature also acknowledges receipt of a copy of special education procedural safeguards (attach SELPA form D/M 77).

Date:		Parent/Guardian/Adult Student Signature:	
Date:		Interpreter Signature:	

LEA USE ONLY – MIS DATA

Date of Referral:		Date Sent to Parent:		Date Signed Assessment Plan Received:		IEP Meeting Date:	

Table 1: Chapter 1 Executive Summary

Section	Proposed Revision(s)	Rev. Date
Chapter 1: Identification and Referral of Individuals for Special Education	• Language to Section E – Interim Placement (Transfer IEP) updated to Interim Placement (Students Transferring into Charter LEA) and section updated to include new forms/processes to meet the California Longitudinal Pupil Achievement Data System (CALPADS) requirements for students with IEPs who transfer: ❖ Between D/M SELPA LEAs; ❖ From an LEA in California which is outside of D/M SELPA; and ❖ From an LEA outside of California	**07/31/2021**

DESERT / MOUNTAIN
CHARTER SELPA

Chapter 1: Identification and Referral of Individuals for Special Education

SECTION A: CHILD FIND

SECTION B: REFERRAL FOR EVALUATION FOR SPECIAL EDUCATION SERVICE

SECTION C: STUDENT STUDY TEAM (SST)

SECTION D: INDIVIDUALIZED EDUCATION PROGRAM (IEP); PROVISION OF FAPE AND LEAST RESTRICTIVE ENVIRONMENT (LRE)

SECTION E: ~~TRANSFER STUDENTS~~ INTERIM PLACEMENT (STUDENTS TRANSFERRING INTO CHARTER LEA)

SECTION F: EARLY IDENTIFICATION OF LEARNING DISABILITIES

SECTION G: OVERIDENTIFICATION AND DISPROPORTIONALITY

SECTION H: STUDENTS WHO ARE CULTURALLY AND LINGUISTICALLY DIVERSE

SECTION I: TEACHING AND ASSESSING CALIFORNIA'S ENGLISH LANGUAGE DEVELOPMENT (ELD) AND ENGLISH LANGUAGE ARTS (ELA) STANDARDS FOR ENGLISH LEARNERS

Introduction

The Desert/Mountain Charter Special Education Local Plan Area (SELPA) recognizes the need to actively seek out and evaluate school-age Charter Local Educational Agency (LEA) residents who have disabilities in order to provide them with appropriate educational opportunities in accordance with state and federal laws.

Charter schools are currently authorized to serve school-age students (Grades 1-12; *Education Code § 47610(c)*). If at any time the authorization changes, the Charter school would follow all state and federal laws regarding children birth to two and Child Find requirements. Charter schools will assist families and make appropriate referrals for any child they find who would be outside the age or area of responsibility of the Charter schools.

team to have optimum information to work with, the child's teacher should provide essential information about the child to the team. In Section F of this chapter the information provided under Student Record Review offers a format for teachers/counselors to prepare information that would be beneficial to the SST. During the meeting, an effective practice to utilize is a group memory format to assist the team in efficient documentation of ideas generated during the meeting. On the action plan that is developed, a follow-up date should be set to review the progress of the child for whom there are concerns. The action plan should be evaluated at this meeting and determination made if any further follow-up is necessary.

Section D – Individualized Education Program (IEP); Provision of Free Appropriate Public Education (FAPE) and Least Restrictive Environment (LRE)

The Charter LEA shall provide educational alternatives that afford children with disabilities full educational opportunities. Children with disabilities shall receive FAPE and be placed in the least restrictive environment that meets their needs to the extent provided by law.

The Charter LEA CEO or designee shall implement the Charter SELPA approved procedural guide that outlines the appointment of the IEP team; the contents of the IEP; and the development, review, and revision of the IEP.

Note: *Education Code § 56055 provides that a foster parent, to the extent permitted by federal law, shall have the same rights relative to his/her foster child's education as a parent. Education Code § 56055 clarifies that this right applies only when the juvenile court has limited the right of a parent to make educational decisions on behalf of his/her child and the child has been placed in a planned permanent living arrangement. Education Code § 56055 defines "foster parent" as a licensed person, relative caretaker, or non-relative extended family member.*

To the extent permitted by federal law, a foster parent shall have the same rights relative to his/her foster child's IEP as a parent *(Education Code § 56055)*.

Section E – ~~Transfer Students~~ Interim Placement (Students Transferring into Charter LEA

Whenever a child with an existing individualized education program (IEP) transfers into a Charter LEA, the Charter LEA shall provide a free appropriate public education (FAPE), including services comparable to those described in the last consented-to IEP. To facilitate ~~a transfer student's~~ the transition from one LEA to another, the Charter LEA shall take reasonable steps to promptly obtain the records of a child with a disability transferring into the Charter LEA, including his/her IEP and the supporting documents related to the provision of special education and related services from the previous school in which the student was enrolled (Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325).

In order to meet the California Longitudinal Pupil Achievement Data System (CALPADS) requirements for **ALL** students with an IEP transferring into an LEA pursuant to Education Code

§ 56325, the receiving LEA, in consultation with the parent/guardian, shall complete the Interim Placement (IP) packet within the Web IEP System. The Interim Placement packet includes:

- the demographics page documenting all relevant information concerning the child,
- the offer of FAPE page documenting their educational program,
- the final page documenting any Special Factors listed on the current IEP from the previous LEA, and
- a signature by a school or district administrator acknowledging the Interim Placement.

A copy of the Interim Placement packet is given to the parent/guardian and forwarded to all related service providers and relevant staff members for implementation of the child's special education program. A copy of the previously approved IEP should be given to the teacher(s), uploaded into the Web IEP system, and placed in the special education pupil file.

If a child with a disability transfers to the Charter LEA during the school year from a Charter LEA within the Desert/Mountain Charter SELPA, the Charter LEA shall continue, without delay, to provide services comparable to those described in the existing IEP, unless the child's parent and Charter LEA agree to develop, adopt, and implement a new IEP that is consistent with state and federal laws (Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325).

If a child with a disability transfers to the Charter LEA during the school year from a California LEA outside of the Desert/Mountain Charter SELPA, the Charter LEA shall provide the child with FAPE, including services comparable to those described in the previous LEA's IEP. Within 30 days, the Charter LEA shall, in consultation with the parents, adopt the other LEA's IEP or shall develop, adopt, and implement a new IEP that is consistent with state and federal laws *(Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325)*. ~~Immediately upon placement of the child, the case carrier shall be responsible for completing page one of the IEP form (D/M 68A), documenting all relevant information concerning the child and his/her educational program. A signature page (D/M 68K) with the following signatures shall be included on the interim IEP:~~

- ~~Parent signature, as well as initials agreeing to a 30-day interim placement;~~
- ~~Administrator or designee signature;~~
- ~~Case carrier signature.~~

~~A copy of the interim IEP is forwarded to the Charter LEA office in order for the child's pertinent information to be entered into the special education database management information system (MIS).~~

~~At the 30-day review meeting, all aspects of the IEP need to be reviewed. New goals and objectives can be developed or the previous ones continued if those goals continue to be in accordance with the child's needs. If the previous goals and objectives are accepted, the next annual review date must align with the previous goal review date.~~

If a child with a disability transfers to the Charter LEA within the Desert/Mountain Charter SELPA during the school year from an out-of-state LEA, the Charter LEA shall provide the child with

FAPE, including services comparable to the out-of-state LEA's IEP, in consultation with the parent, until such time as the Charter LEA conducts an assessment, if the Charter LEA determines that such an assessment is necessary, and develops, adopts, and implements a new IEP, if appropriate *(Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325)*.

The law allows an LEA to address the IEP within the LEA's existing programs and services to the greatest extent possible for a period not to exceed the 30-day placement; therefore, it is not necessary for the parent/guardian to sign the proposed Interim Placement (IP) form. When programs or services that were provided in the former district are not in place in the new LEA at the time of enrollment, an alternative program within the LEA, a referral to a program operated by another agency, or placement in a nonpublic school may be necessary. The parent must give consent for placement in a program that is not in conformity with the current IEP.

When the IEP team meets for the 30-day review, the IEP team shall review all aspects of the IEP through the IEP process. Whether the LEA adopts the previously approved individualized education program or develops, adopts, and implements a new individualized education program, the next annual review date must align with the previous goal review date.

Section F - Early Identification of Learning Disabilities

> ***California Education Code § 49580****. The California Department of Education shall develop the testing programs to be utilized at the kindergarten grade level to determine which pupils have a potential for developing learning disability problems. The testing procedure shall include an overall screening test for learning disabilities and testing for dyslexia. To the extent feasible, the department shall use existing tests and screening instruments in developing the early diagnosis of the learning disabilities testing program. In developing the program, the department shall consult with experts in the areas of learning and reading difficulties, including, but not limited to, neurologists, psychologists, persons working in these areas in postsecondary educational institutions, teachers, school nurses, education consultants, school psychologists, and other persons with appropriate knowledge and experience in the detection and treatment of learning problems and reading difficulties in early grades.*

> ***California Education Code § 49582****. The California Department of Education shall prescribe guidelines for the early diagnosis of the learning disabilities testing program and pilot project.*

Student Record Review

Review the child's educational records with attention to the following:

- Amount and quality of classwork and homework, with work samples provided at the meeting;

DESERT / MOUNTAIN
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Chapter 1: Identification and Referral of Individuals for Special Education

SECTION A: CHILD FIND

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SECTION D: INDIVIDUALIZED EDUCATION PROGRAM (IEP); PROVISION OF FAPE AND LEAST RESTRICTIVE ENVIRONMENT (LRE)

SECTION E: INTERIM PLACEMENT (STUDENTS TRANSFERRING INTO CHARTER LEA)

SECTION F: EARLY IDENTIFICATION OF LEARNING DISABILITIES

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Introduction

The Desert/Mountain Charter Special Education Local Plan Area (SELPA) recognizes the need to actively seek out and evaluate school-age Charter Local Educational Agency (LEA) residents who have disabilities in order to provide them with appropriate educational opportunities in accordance with state and federal laws.

Charter schools are currently authorized to serve school-age students (Grades 1-12; *Education Code § 47610(c)*). If at any time the authorization changes, the Charter school would follow all state and federal laws regarding children birth to two and Child Find requirements. Charter schools will assist families and make appropriate referrals for any child they find who would be outside the age or area of responsibility of the Charter schools.

The Charter LEA Chief Executive Officer (CEO) or designee shall implement the designated Charter SELPA process to determine when an individual is eligible for special education services and shall implement the Charter SELPA procedures for special education program identification, screening, referral, assessment, planning, implementation, review, and triennial assessment *(Education Code § 56301)*. The Charter LEA's process shall prevent the inappropriate disproportionate representation by race and ethnicity of children with disabilities. Note: *The Individuals with Disabilities Education Act (IDEA), Title 20 of the United States Code § 1412(a)(3), requires that the Charter LEA's "child find" identification system include identification of children with disabilities resident in the Charter LEA including highly mobile children with disabilities, such as migrant and homeless children.*

Services for a private school student, in accordance with an Individualized Education Program (IEP), must be provided by the Charter LEA at no cost to the parent, unless the Charter LEA makes a Free Appropriate Public Education (FAPE) available to the child and the parent chooses to enroll the child in that private school. If the public school is providing services to the child, these services may be provided on the premises of the private school, including a parochial school, to the extent consistent with other provisions of law. Title 34 of the Code of Federal Regulations § 300.451 requires the Charter LEA to consult with appropriate representatives for private school students on how to carry out the "child find" requirement.

The Charter LEA CEO or designee shall implement the designated Charter SELPA's method whereby parents, teachers, appropriate professionals, and others may refer an individual for assessment for special education services. Identification procedures shall be coordinated with school site procedures for referral of children with needs that cannot be met with modifications to the general instructional program *(Education Code § 56302)*.

For assessment purposes, staff shall use appropriate tests to identify specific information about the child's abilities in accordance with Education Code § 56320.

The Charter LEA CEO or designee shall notify parents in writing of their rights related to identification, referral, assessment, instructional planning, implementation, and review, including the Charter SELPA's procedures for initiating a referral for assessment to identify individuals who need special education services *(Education Code § 56301)*.

The referral for special education assessment is the first step taken when it is suspected that a child will require special education supports and services to be successful in the educational system. Parents, teachers, agencies, appropriate professionals, and other members of the public can make referrals. Once submitted, the referral initiates timelines that are specified in the Education Code. The purpose of the referral process is to afford the assessment team the opportunity to review the referring party's identified areas of concern, previous attempts in program modification, relevant educational history, and other pertinent information about the child to determine areas in need of assessment.

Section A – Child Find

It is the policy of the Charter SELPA that children with disabilities age six through 21 be actively sought and identified by the public schools. The child find process includes a section of the Charter

LEA's annual notice to all parents that references the referral of children with disabilities. All children with disabilities and their parents are guaranteed their procedural safeguards with regard to identification, assessment, and placement in special education programs.

School personnel, parents, outside agencies working with the child, guardians and/or surrogate parents who show legal documentation of educational rights may all serve as sources of referral for a child for possible identification as a child with a disability. Such identification procedures shall be coordinated with school site and Charter LEA procedures for referral of children with needs that cannot be met with modification of the general education instructional program.

> ***California Education Code § 47640.*** *For the purposes of this article, "local educational agency" means a school district as defined in Section 41302.5 or a charter that is deemed a local educational agency pursuant to Section 47641. As used in this article, "local educational agency" also means a charter school that is responsible for complying with all provisions of the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.) and implementing regulations as they relate to local educational agencies.*

> ***California Education Code § 47641.*** *(a) A charter school that includes in its petition for establishment or renewal, or that otherwise provides, verifiable, written assurances that the charter school will participate as a local educational agency in a special education plan approved by the State Board of Education shall be deemed a local educational agency for the purposes of compliance with federal law (Individuals with Disabilities Education Act; 20 U.S.C. Sec. 1400 et seq.) and for eligibility for federal and state special education funds. A charter school that is deemed a local educational agency for the purposes of special education pursuant to this article shall be permitted to participate in an approved special education local plan that is consistent with subdivision (a), (b), or (c) of Section 56195.1.*

> ***California Education Code § 56300.*** *A local educational agency shall actively and systematically seek out all individuals with exceptional needs, from birth to 21 years of age, inclusive, including children not enrolled in public school programs, who reside in a school district or are under the jurisdiction of a special education local plan area or a county office of education.*

> ***California Education Code § 56301(a).*** *All children with disabilities residing in the state, including children with disabilities who are homeless children or are wards of the state and children with disabilities attending private, including religious, elementary and secondary schools, regardless of the severity of their disabilities, and who are in need of special education and related services, shall be identified, located, and assessed and a practical method is developed and implemented to determine which children with disabilities are currently receiving needed special education and related services.*

Identification and Evaluation of Children Younger than Three

Identification, evaluation, assessment, and instructional planning procedures for children younger than three must conform to Education Code §§ 56425-56432, and the California Early Intervention Services Act Government Code §§ 95000-95029. The California Department of Education (CDE) and LEAs are responsible for providing early intervention services to infants and toddlers who have visual, hearing, or severe orthopedic impairment; the Department of Developmental Services (DDS) and its regional centers must provide services to all other eligible children in this age group. The law also requires regional centers and LEAs to coordinate family service plans for infants and toddlers and their families. Education Code § 56441.11 sets forth eligibility criteria for preschool children age three to five.

A child age three through five enrolled by his/her parents in a private school or facility that does not meet the state's definition of "elementary school" would not be eligible to be considered for equitable services. However, the state's obligation to make FAPE available to such a child remains. IDEA requires that states make FAPE available to eligible children with disabilities age three through 21 in the state's mandated age range (Title 34 of the Code of Federal Regulations § 300.101). Because many LEAs do not offer public preschool programs, particularly for three and four year-olds, LEAs often make FAPE available to eligible preschool children with disabilities in private schools or facilities in accordance with Title 34 of the Code of Federal Regulations §§ 300-145 through 300.147. In these circumstances, there is no requirement that the private school or facility be an "elementary school" under state law.

> ***Title 34 of the Code of Federal Regulations § 300.13.*** *Elementary school means a nonprofit institutional day or residential school, including a public elementary charter school that provides elementary education, as determined under State law.*

Section B – Referral for Evaluation for Special Education Services

A child shall be referred for special education instruction and services only after the resources of the general education program have been considered and used where appropriate (Education Code § 56303).

Education Code § 56329, provides that, when making a determination of eligibility for special education and related services, Charter LEAs shall not determine that a child is a child with a disability if the primary factor for such determination is a lack of appropriate instruction in reading, including the essential components of reading instruction pursuant to Title 20 of the United States Code § 6368 of the No Child Left Behind Act, lack of instruction in math, or limited English proficiency (LEP).

California Education Code § 56301(d)(1). Each special education local plan area shall establish written policies and procedures pursuant to Section 56205 for use by its constituent local agencies for a continuous child find system that addresses the relationships among identification, screening, referral, assessment, planning, implementation, review, and the triennial assessment. The policies and procedures shall include, but need not be limited to, written notification of all parents of their

rights under this chapter, and the procedure for initiating a referral for assessment to identify individuals with exceptional needs.

All referrals for special education and related services from school staff shall include a brief reason for the referral and description of the general education program resources that were considered and/or modified for use with the child, and their effect (Title 5 of the California Code of Regulations § 3021).

Referrals for special education and related services initiate the process to determine if an assessment is warranted and shall be documented. When a verbal referral is made, staff of the Charter LEA shall offer assistance to the parent or any other individual to make a request in writing. The Charter SELPA shall annually distribute information regarding child find activities to private schools for dissemination to parents.

Parents whose primary language is not English shall be informed of the need to file a written request when a verbal request is made. They shall be informed both verbally and in writing in their primary language, unless to do so is clearly not feasible. Assistance in providing a written request will be provided as needed. Written referrals in languages other than English will be accepted.

If a parent requests, in writing, an assessment for possible special education services, the Charter LEA will develop an Assessment Plan (D/M 66) and present it to the parent within 15 days. The proposed assessment may include a classroom observation, review of records, informal screening, and/or a referral for a formal evaluation in suspected areas of disability, such as, but not limited to, vision/hearing, speech-language, academic skills, cognition, adaptive behavior, psychological processing skills, or social-emotional-behavioral status. A copy of the Procedural Safeguards/ Parents' Rights (D/M 77) are reviewed and given to the parents at the time the assessment plan is presented. The 15-day period does not include days between the child's regular school session or term or days of school vacation in excess of five school days from the date of receipt of the referral. Charter SELPA forms are available on the website at www.cahelp.org for member Charter LEAs to use upon receipt of a referral for special education assessment (D/M 51 - Identification, Referral, Assessment Log for the IEP Process; D/M 56 - Family Information; D/M 57 - Referral for Special Education; D/M 58 - Educational History and Social Achievement; D/M 59 - Checklist for Student Observation; D/M 63 - Authorization for Use and/or Disclosure of Information; and D/M 79 - Utilized Interventions).

However, an IEP required as a result of an assessment of a child shall be developed within 30 days after the commencement of the subsequent regular school year as determined by each Charter LEA's school calendar for each child for whom a referral has been made 30 days or less prior to the end of the regular school year. In the case of school vacations, the 60-day time shall recommence on the date that school days reconvene. A meeting to develop an initial IEP for the child shall be conducted within 30 days of a determination that the child needs special education and related services pursuant to Title 34 of the Code of Federal Regulations § 300.343(2)(b); Education Code § 56344.

The proposed assessment plan shall meet all of the following requirements (Education Code § 56321):

- Be in a language easily understood by the general public;
- Be provided in the native language of the parent or other mode of communication used by the parent unless it is clearly not feasible;
- Explain the types of assessment to be conducted;
- State that no IEP will result from the assessment without parental consent.

All initial referrals resulting from child find of children ages three to five shall be processed through the Charter LEA. The informed parental consent for assessment (D/M 66) shall be completed by the person interacting with the parent and forwarded to the appropriate member of the Charter LEA preschool assessment team (i.e., psychologist, nurse, speech-language pathologist).

For a preschool-age child, a member of the Charter LEA preschool assessment team will contact the parent to discuss concerns, or arrange a home visit for observation.

For a school-age child, the referral for special education assessment may include a referral to the Student Study Team (SST) and/or the scheduling of a parent conference to discuss the concerns and possible interventions.

Upon receiving the proposed assessment plan, the parent shall have at least 15 days to decide whether or not to consent to the initial assessment. The assessment may begin as soon as informed parental consent is received by the respective Charter LEA. The Charter LEA shall not interpret parental consent for initial assessment as consent for initial placement or initial provision of special education services *(Education Code § 56321; Title 34 of the Code of Federal Regulations § 300.505). Note: Education Code § 56321 provides that, if a parent refuses to consent to the initial evaluation, the Charter LEA may pursue an evaluation by utilizing the mediation and due process procedures pursuant to Title 20 of the United States Code § 1415. In the event that an evaluation is not authorized, Title 20 of the United States Code § 1414(a)(1) specifies that the Charter LEA shall not provide special education services and shall not be considered in violation of the requirement to provide FAPE for failure to provide such services. In addition, the Charter LEA is not required to convene an IEP team meeting or to develop an IEP for that child.*

Informed parental consent means that the parent (Title 34 of the Code of Federal Regulations § 300.500):

- Has been fully informed of all information relevant to the activity for which consent is sought, in his/her native language or other mode of communication;
- Understands and agrees, in writing, to the assessment;
- Understands that the granting of consent is voluntary on his/her part and may be revoked at any time.

If the child is a ward of the state and is not residing with his/her parents, Charter LEAs shall make reasonable efforts to obtain informed consent from the parent as defined in Title 20 of the United

States Code § 1401 for an initial evaluation to determine whether the child is a child with a disability *(Title 20 of the United States Code § 1414(a)(1)).*

The Charter LEA shall not be required to obtain informed consent from the parent for an initial evaluation to determine whether the child is a child with a disability if any of the following situations exist (Education Code § 56301; Title 20 of the United States Code § 1414(a)(1)):

1. Despite reasonable efforts to do so, the Charter LEA cannot discover the whereabouts of the parent of the child;
2. The rights of the parent of the child have been terminated in accordance with California law;
3. The rights of the parent to make educational decisions have been subrogated by a judge in accordance with California law and consent for an initial evaluation has been given by an individual appointed by the judge to represent the child.

As part of the assessment plan, the parent shall receive written notice that *(Education Code § 56329; Title 34 of the Code of Federal Regulations § 300.502)*:

1. Upon completion of the administration of tests and other assessment materials, an IEP team meeting that includes the parent or his/her representative shall determine whether or not the child is a child with a disability as defined in Education Code § 56026 and shall discuss the assessment, the educational recommendations, and the reasons for these recommendations. A copy of the assessment report and the documentation of determination of eligibility shall be given to the parent.
2. If the parent disagrees with an assessment obtained by the Charter LEA, the parent has the right to obtain, at public expense, an independent educational assessment of the child from qualified specialists, in accordance with Title 34 of the Code of Federal Regulations § 300.502.

   If the Charter LEA observed the child in conducting its assessment, or if its assessment procedures make it permissible to have in-class observation of a child, an equivalent opportunity shall apply to the independent educational assessment. This equivalent opportunity shall apply to the child's current placement and setting as well as observation of the Charter LEA's proposed placement and setting, regardless of whether the independent educational assessment is initiated before or after the filing of a due process hearing proceeding.
3. The Charter LEA may initiate a due process hearing pursuant to Education Code §§ 56500-56508 to show the assessment is appropriate. If the final decision resulting from the due process hearing is that the assessment is appropriate, the parent maintains the right for an independent educational assessment but not at public expense.

   If the parent obtains an independent educational assessment at private expense, the results of the assessment shall be considered by the Charter LEA with respect to the provision of FAPE, and may be presented as evidence at a due process hearing regarding the child. If the Charter LEA observed the child in conducting its assessment, or if its assessment procedures make it permissible to have in-class observation of a child, an equivalent opportunity shall apply to an independent educational assessment of the child in the child's

current educational placement and setting, if any, proposed by the Charter LEA, regardless of whether the independent educational assessment is initiated before or after the filing of a due process hearing.

4. If a parent proposes a publicly financed placement of the child in a nonpublic school, the Charter LEA shall have an opportunity to observe the proposed placement and, if the child has already been unilaterally placed in the nonpublic school by the parent, the child in the proposed placement. Any such observation shall only be of the child who is the subject of the observation and may not include the observation or assessment of any other student in the proposed placement unless that student's parent consents to the observation or assessment. The results of any observation or assessment of another student in violation of Education Code § 56329(d) shall be inadmissible in any due process or judicial proceeding regarding the FAPE of that other student.

An IEP required as a result of an assessment shall be developed within a total time not to exceed 60 days, not counting days between the child's regular school sessions, terms, or days of school vacation in excess of five school days, from the date of the receipt of the parent's consent for assessment, unless the parent agrees, in writing, to an extension (Education Code § 56043).

Before entering kindergarten or first grade, children with disabilities who are in a preschool program shall be reassessed to determine if they still need special education and services. IEP teams shall identify a means of monitoring the continued success of children who are determined to be eligible for less intensive special education programs to ensure that gains made are not lost by a rapid removal of individualized programs and supports for these individuals (Education Code § 56445).

Section 504

Children may be referred for assessment under Section 504 of the Rehabilitation Act of 1973 by parents, school staff, or agencies. Each Charter LEA has defined written Section 504 procedures to assess and meet the educational needs of general education students who are otherwise disabled due to a physical or mental impairment which substantially limits one or more major life activities.

Section C – Student Study Team (SST)

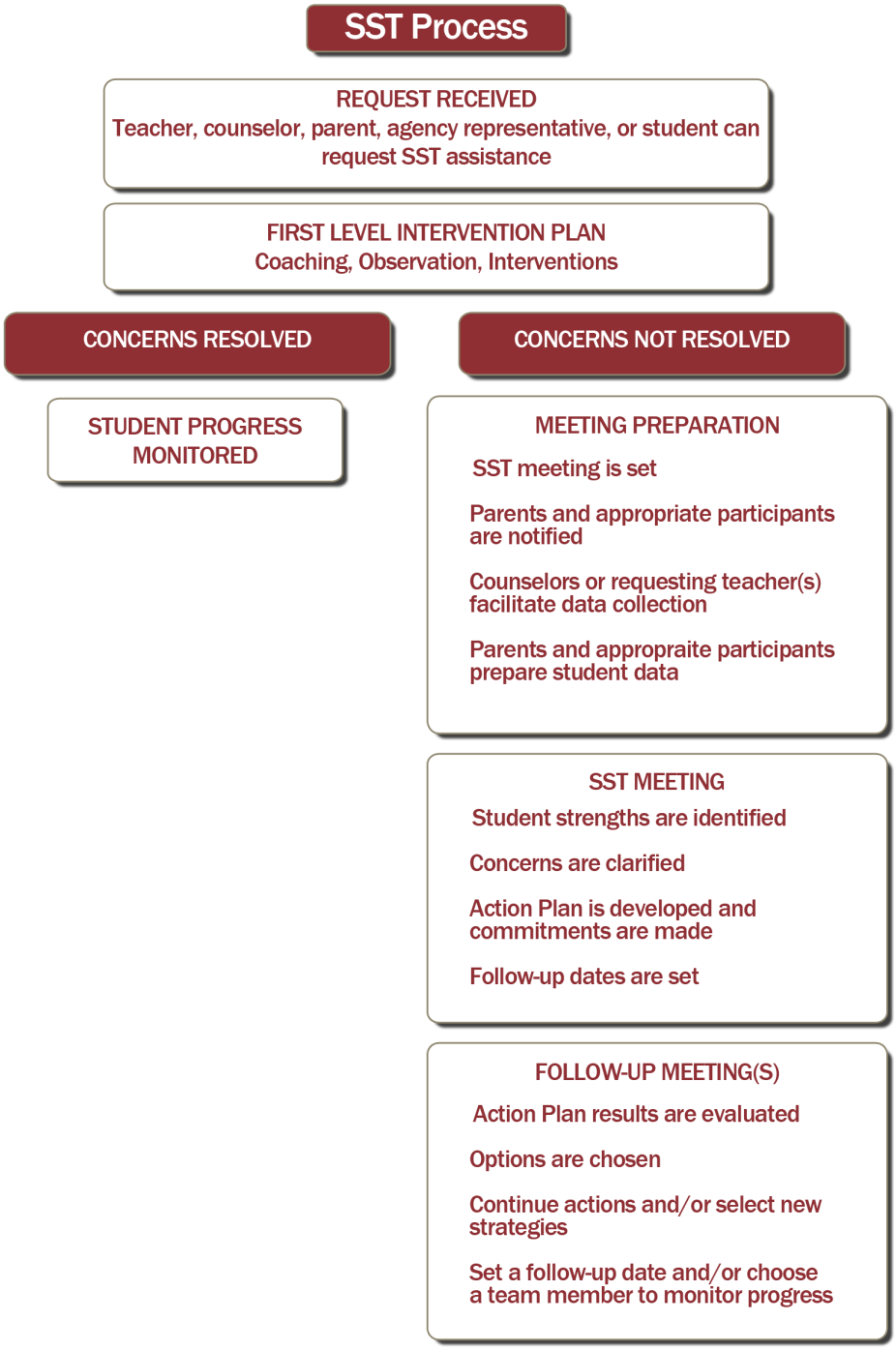
> ***California Education Code § 56303.*** *A pupil shall be referred for special educational instruction and services only after the resources of the regular education program have been considered and, where appropriate, utilized.*

Procedures have been developed in each Charter LEA for the receipt and processing of referrals for special education assessment. In all LEAs, the school site Student Study Team (SST) meets regarding children for whom there are concerns. The team addresses the implementation and level of success of the general education classroom program modifications and available general education resources and programs, including categorical programs. When the SST determines that all possible modifications have been exhausted or the modifications available are not appropriate, the SST or classroom teacher refers the child for an assessment for possible special education

services. The parent is informed and encouraged to be a part of the SST process. Parents are notified if a referral for a special education assessment is made by the team.

The SST is a regularly scheduled, structured meeting of general educators, supported by special educators and other staff as appropriate. Their purpose is to provide an effective support system in general education that will generate effective interventions for children who are experiencing challenges in learning or behavior difficulties at school. The SST process is designed to meet the needs of all children and result in a team action plan to ensure student success. The structure of the SST may be designed to fit the needs of individual school sites. Team membership varies according to the needs of the child, but should include the people that can best support the child and the classroom teacher. The majority of the team membership must be composed of general education teachers and should include the following team members: the child's classroom teacher, an administrator, the parent, the child, an upper grade teacher, and a lower grade teacher. The SST should also serve as a peer support system, so the more teacher participation the greater the benefits. Specialists should be included based on the potential needs of the child, the classroom teacher, and any others providing support to the child.

The following describes the **SST Process**:



The process begins with a request from a teacher, counselor, parent, agency representative, or child that a concern has been identified. Once the request is made, the school's first-level intervention plan is implemented. It is important to note that a request does not automatically initiate a SST meeting. If the concerns can be resolved without a SST meeting, then the child is monitored for successful progress. If the concerns are not resolved, SST meeting preparation is started. For the

team to have optimum information to work with, the child's teacher should provide essential information about the child to the team. In Section F of this chapter the information provided under Student Record Review offers a format for teachers/counselors to prepare information that would be beneficial to the SST. During the meeting, an effective practice to utilize is a group memory format to assist the team in efficient documentation of ideas generated during the meeting. On the action plan that is developed, a follow-up date should be set to review the progress of the child for whom there are concerns. The action plan should be evaluated at this meeting and determination made if any further follow-up is necessary.

Section D – Individualized Education Program (IEP); Provision of Free Appropriate Public Education (FAPE) and Least Restrictive Environment (LRE)

The Charter LEA shall provide educational alternatives that afford children with disabilities full educational opportunities. Children with disabilities shall receive FAPE and be placed in the least restrictive environment that meets their needs to the extent provided by law.

The Charter LEA CEO or designee shall implement the Charter SELPA approved procedural guide that outlines the appointment of the IEP team; the contents of the IEP; and the development, review, and revision of the IEP.

Note: *Education Code § 56055 provides that a foster parent, to the extent permitted by federal law, shall have the same rights relative to his/her foster child's education as a parent. Education Code § 56055 clarifies that this right applies only when the juvenile court has limited the right of a parent to make educational decisions on behalf of his/her child and the child has been placed in a planned permanent living arrangement. Education Code § 56055 defines "foster parent" as a licensed person, relative caretaker, or non-relative extended family member.*

To the extent permitted by federal law, a foster parent shall have the same rights relative to his/her foster child's IEP as a parent *(Education Code § 56055)*.

Section E – Interim Placement (Students Transferring into Charter LEA)

Whenever a child with an existing individualized education program (IEP) transfers into a Charter LEA, the Charter LEA shall provide a free appropriate public education (FAPE), including services comparable to those described in the last consented-to IEP. To facilitate the transition from one LEA to another, the Charter LEA shall take reasonable steps to promptly obtain the records of a child with a disability transferring into the Charter LEA, including his/her IEP and the supporting documents related to the provision of special education and related services from the previous school in which the student was enrolled (Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325).

In order to meet the California Longitudinal Pupil Achievement Data System (CALPADS) requirements for **ALL** students with an IEP transferring into an LEA pursuant to Education Code

§ 56325, the receiving LEA, in consultation with the parent/guardian, shall complete the Interim Placement (IP) packet within the Web IEP System. The Interim Placement packet includes:

- the demographics page documenting all relevant information concerning the child,
- the offer of FAPE page documenting their educational program,
- the final page documenting any Special Factors listed on the current IEP from the previous LEA, and
- a signature by a school or district administrator acknowledging the Interim Placement.

A copy of the Interim Placement packet is given to the parent/guardian and forwarded to all related service providers and relevant staff members for implementation of the child's special education program. A copy of the previously approved IEP should be given to the teacher(s), uploaded into the Web IEP system, and placed in the special education pupil file.

If a child with a disability transfers to the Charter LEA during the school year from a Charter LEA within the Desert/Mountain Charter SELPA, the Charter LEA shall continue, without delay, to provide services comparable to those described in the existing IEP, unless the child's parent and Charter LEA agree to develop, adopt, and implement a new IEP that is consistent with state and federal laws (Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325).

If a child with a disability transfers to the Charter LEA during the school year from a California LEA outside of the Desert/Mountain Charter SELPA, the Charter LEA shall provide the child with FAPE, including services comparable to those described in the previous LEA's IEP. Within 30 days, the Charter LEA shall, in consultation with the parents, adopt the other LEA's IEP or shall develop, adopt, and implement a new IEP that is consistent with state and federal laws *(Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325)*.

If a child with a disability transfers to the Charter LEA within the Desert/Mountain Charter SELPA during the school year from an out-of-state LEA, the Charter LEA shall provide the child with FAPE, including services comparable to the out-of-state LEA's IEP, in consultation with the parent, until such time as the Charter LEA conducts an assessment, if the Charter LEA determines that such an assessment is necessary, and develops, adopts, and implements a new IEP, if appropriate *(Title 34 of the Code of Federal Regulations § 300.323; Education Code § 56325)*.

The law allows an LEA to address the IEP within the LEA's existing programs and services to the greatest extent possible for a period not to exceed the 30-day placement; therefore, it is not necessary for the parent/guardian to sign the proposed Interim Placement (IP) form. When programs or services that were provided in the former district are not in place in the new LEA at the time of enrollment, an alternative program within the LEA, a referral to a program operated by another agency, or placement in a nonpublic school may be necessary. The parent must give consent for placement in a program that is not in conformity with the current IEP.

When the IEP team meets for the 30-day review, the IEP team shall review all aspects of the IEP through the IEP process. Whether the LEA adopts the previously approved individualized education program or develops, adopts, and implements a new individualized education program, the next annual review date must align with the previous goal review date.

Section F - Early Identification of Learning Disabilities

> ***California Education Code § 49580****. The California Department of Education shall develop the testing programs to be utilized at the kindergarten grade level to determine which pupils have a potential for developing learning disability problems. The testing procedure shall include an overall screening test for learning disabilities and testing for dyslexia. To the extent feasible, the department shall use existing tests and screening instruments in developing the early diagnosis of the learning disabilities testing program. In developing the program, the department shall consult with experts in the areas of learning and reading difficulties, including, but not limited to, neurologists, psychologists, persons working in these areas in postsecondary educational institutions, teachers, school nurses, education consultants, school psychologists, and other persons with appropriate knowledge and experience in the detection and treatment of learning problems and reading difficulties in early grades.*

> ***California Education Code § 49582****. The California Department of Education shall prescribe guidelines for the early diagnosis of the learning disabilities testing program and pilot project.*

Student Record Review

Review the child's educational records with attention to the following:

- Amount and quality of classwork and homework, with work samples provided at the meeting;
- Test data, curriculum-based data, math, reading, language, and spelling levels;
- Indicators of resiliency, ability to handle stress, and emotional intelligence;
- Attendance;
- Hearing and vision screening results, and health issues;
- Behaviors observed in class or on the playground that are of concern;
- Retention or referral to other programs; and
- Contacts with the family.

Be prepared to present specific background information about the child, including strengths, interests, and career potential. The strengths and specific interests that motivate the child are the building blocks for the student success plan. Building on them will help the team be more creative while brainstorming strategies and designing the action plan. Examples of strengths are: good in math; likes to read; enjoys art and music; loves to sing; works well on a computer; writes creatively; did an exceptional science project; wants to please adults; and chosen by classmates as a friend and/or leader.

Identify basic concerns, the behaviors that need intervention, and the desired outcomes. Examples of concerns are: reading or math is below grade level; handwriting is difficult to read; completes only 25% of classwork; does not return homework; distracts others during lessons; does not participate in group discussions; and pushes students during recess. Examples of desired outcomes are: better attendance; increase in reading or math skills; passing competency tests; working well with peer tutor; and ability to follow specific playground rules.

Use the Modifications Checklist to indicate the general education modifications that have been tried.

Section G – Overidentification and Disproportionality

It shall be the policy of the Desert/Mountain Charter SELPA and its member LEAs to prevent inappropriate disproportionate representation by race and ethnicity of students with disabilities.

> ***Title 34 of the Code of Federal Regulations § 300.173****. Overidentification and disproportionality. The State must have in effect, consistent with the purposes of this part and with section 618(d) of the Act, policies and procedures designed to prevent the inappropriate overidentification or disproportionate representation by race and ethnicity of children as children with disabilities, including children with disabilities with a particular impairment described in section 300.8.*

The Charter LEA shall, with Charter SELPA assistance, monitor student trends with the intent of averting inappropriate, disproportionate representation of racially, ethnically, linguistically, and culturally diverse students (by race and ethnicity of children with disabilities). The Charter SELPA shall provide the following assistance:

- Student trend data pertinent to the disproportionate calculation as reported through the California Special Education Management Information System (CASEMIS) to the California Department of Education (CDE);
- Provide up-to-date training and information provided to the Charter SELPA by the CDE;
- Continue to inform Charter LEAs concerning responsibilities related to the potential transfer of local assistance funds to reduce disproportionality under the Early Intervening requirement of IDEA.

The CDE has in effect, consistent with the purposes of IDEA and with Section 618(d), policies and procedures designed to prevent the inappropriate overidentification or disproportionate representation by race and ethnicity of children as children with disabilities, including children with disabilities with a particular impairment described in Section 602(3).

Section H – Students who are Culturally and Linguistically Diverse

Children who are culturally and linguistically diverse have four initial areas of consideration for their school program. First, the language of instruction is considered. According to the IDEA 2004,

some children will need special education, which could include related speech and language services. While language diversity may be one of the most frequently discussed topics concerning academic achievement, it is important for an IEP team to consider and document the effect of a child being a second-language learner on his or her ability to make progress in the general education curriculum.

To choose the language of instruction, the IEP team must consider where on the continuum of language acquisition the child assesses for both the primary language and English. The Speech-Language Pathologist (SLP) is consulted to interpret the child's pragmatic and socialization aspects of language, which include eye contact, facial expression, nonverbal messages, and tone. These assessment data are used to determine if errors are made because of a lack of exposure to the curriculum and if exposure has been adequate to master the primary language. A determination is made as to whether the child is struggling with second-language learning or has one or more disabilities that impact learning progress.

Questions developed by Ortiz and Garcia (1988) guide the IEP team through this decision process:

1. What is the child's dominant language in various settings?
2. What is the child's level of proficiency in both the primary language and English for social and academic language?
3. What are the styles of verbal interaction used in the primary language and English?
4. How much exposure has the child had to verbal interactions in English?
5. What is the source of exposure to each language (family, peers, TV, book reading, etc.)?
6. Are the child's language behaviors characteristic of other second-language learners?
7. What types of language intervention has the child already had and what is the duration and outcome of those interventions?

For further information, refer to Education Code §§ 313 and 420 - 421.

The second area of consideration for English Learners (ELs) is for authorization of the teacher to provide instruction. The Bilingual, Cross-cultural, Language and Academic Development (BCLAD) and Cross-cultural, Language and Academic Development (CLAD) certification is required for teaching English language development. The Specially Designed Academic Instruction in English (SDAIE) authorization is required to teach English language development and content for the core subjects in the primary language. Contact your Charter LEA office to verify appropriate certification for teachers of children who are English Learners and who are receiving the core curriculum in English and for those children who are English Learners, but are learning core curriculum in their primary language.

Another consideration is the use of interpreters and translators. It is noted that *interpretation* is for oral language, while *translation* refers to written language. Using an interpreter or translator is a method of choice when the pathologist who is assigned to provide therapy is not fluent enough to provide therapy in both languages. Guidance is provided for service delivery in a resource titled Working Successfully with Interpreters and Translators in Speech-Language Pathology and Audiology, written by Langdon and Cheng.

Children with accents and dialects may be referred for special education services, speech services, or viewed as low achievers. Current efforts by the American Speech and Hearing Association (ASHA), consider these referrals misguided. The organization is attempting to avoid these potential discriminatory actions. An accent is defined as a phonetic trait from a primary language that is carried over to the way a second language is spoken. The level of pronouncement of an accent on the second language depends upon the age and circumstances under which the second language was acquired. A dialect is defined as differences that make one English speaker's speech different from another. Dialects have distinguishing characteristics, which may include: phonology, morphology, semantics, syntax, or pragmatics.

Dialects and accents are considered language variations that are accepted differences in speech (Cole, 1983). A determination by the IEP team to provide special education services must be grounded on what children who are culturally and linguistically diverse need to be successful based on academic standards, not on accent or dialect differences.

The fourth and final consideration, working with families, is one that shows respect and increases the possibility of carry-over from school interventions to the home setting. In addition to cohesive planning during the IEP process, family literacy programs supported by the Charter LEA have been especially meaningful for those who are culturally and linguistically diverse.

The information for this section is attributed to Barbara J. Moore-Brown and Judy K. Montgomery. Their book, Making a Difference for America's Children, Speech-Language Pathologists in Public Schools, 2001, is available from Thinking Publications.

In referring culturally and linguistically diverse children for special education services, care must be taken to determine whether learning, language-speech, and/or behavior problems demonstrated by the child indicate a disability or, instead, manifest cultural, experiential, and/or socio-linguistic differences.

A. All English Learners (ELs) in special education programs must,

- Receive an English Language Development (ELD) curriculum approved by the Charter LEA;
- All academic IEP goals for ELs must be linguistically/culturally appropriate;
- ELD standards are aligned with the Common Core standards and should be used when writing goals for ELs.

Please refer to the following documents posted on the Desert//Mountain Charter SELPA website for in-depth information regarding special education assessment, IEP development, and re-classification criteria: English Language Proficiency Assessments for California (ELPAC) on the CDE website at https://www.cde.ca.gov/ta/tg/ep/

B. In General: Child Find/Pre-Referral Activities

It is especially important for the SST to determine whether accommodations and supports in the general education curriculum or in the manner in which instruction is provided may assist the child in overcoming their learning, language-speech, and/or behavioral problems. The

child's teacher and SST should gather the following information about the child to help make this determination:

- Background;
- Culture and language;
- Acculturation level;
- Socio-linguistic development; and
- Data showing the child's response to the school and classroom environment when accommodations and supports are provided.

C. Cultural and Linguistic Interventions

Interventions to help resolve difficulties that arise from differences in cultural and linguistic background or from difficulties with the schooling process might include:

- Cross-cultural counseling and
- Peer support groups.

D. Socio-Linguistic Interventions

Interventions to help resolve difficulties that arise from differences in socio-linguistic development might include:

- Instruction in English language development;
- Bilingual assistance;
- Native language development; and
- Assistance in developing basic interpersonal communication skills.

E. In General: English Learners Receiving Special Education Services

(1) IEP Team Membership

(a) At least one of the Charter LEA IEP team members must have a credential or certification to teach ELs. That person must indicate, next to their signature on the IEP, which credential or certification they possess (e.g., Bilingual Cross-cultural Language and Academic Development (BCLAD) or Cross-cultural Language and Academic Development (CLAD), etc.).

(b) If the parent has limited English skills, an interpreter must be present at the IEP meeting.

The interpreter must sign the IEP; however, the interpreter is not a participating member of the team. The interpreter's role is only to interpret.

(2) Present Levels of Performance

In addition to previously discussed information:

(a) Identify the language proficiency assessment instruments(s) used and interpret the results (English Language Proficiency Assessments or California (ELPAC));

(b) Use the assessment results to indicate the child's instructional program (Biliteracy, Sheltered, Mainstream English Immersion, ELD, etc.) and language of instruction; and

(c) Identify who will provide the ELD instruction guideline: If the child is removed from English instruction for special education services, that teacher/specialist is the ELD teacher.

(3) Goals/Objectives

The following rubric should be considered for each goal and objective to ensure that it meets the definition of being culturally and linguistically appropriate:

(a) States specifically in what language the particular goal and objective will be accomplished;

(b) Is appropriate to the child's level of linguistic development and proficiency in that language;

(c) Consistent with the known developmental structure of that language; and

(d) Provides cultural relevance in the curricular framework.

Refer to the document English Language Proficiency Assessments for CA – CalEdFacts on the CDE website at https://www.cde.ca.gov/ta/tg/ep/cefelpac.asp for more information.

F. Instructional Program Options

The following is a list of the instructional programs that are offered for students who are EL:

(1) Biliteracy

(a) For Spanish speaking children at the emerging, early expanding, and bridging level;

(b) Children who are grouped for instruction in full classroom configuration. The focus is in developing proficiency in both English and Spanish. The instructional emphasis is on ELD and initial access to core curriculum. There is an increase of English as the language of instruction over time; and

(c) Classes must be taught by a teacher with a BCLAD credential or equivalent certification.

(2) Structured English Immersion with Spanish Instructional Support

(a) For Spanish speaking children at the emerging, early expanding, and bridging level;

(b) Children are grouped for instruction in full classroom configuration. The focus is on developing proficiency in English through ELD and Specially Designed Academic Instruction delivered in English (SDAIE), using Spanish as an instructional support; and

(c) Classes must be taught by a teacher with a BCLAD credential or equivalent certification.

(3) Structured English Immersion – Sheltered

(a) For children at the emerging, early expanding, and bridging level;

(b) Classes may be comprised of speakers of many languages. Children are grouped for instruction in full classroom configuration. Children may also be grouped in clusters (about 1/3 English Learners) by English language proficiency. The focus is on developing proficiency in English through ELD and SDAIE strategies; and

(c) Classes must be taught by a teacher with a CLAD credential or equivalent certification.

(4) Mainstream English Cluster

(a) For children in the early advanced to advanced proficiency level;

(b) Classes are designed for children who have a good working knowledge of English. The children are clustered, approximately 1/3 English Learners within a grade level classroom. Instructional emphasis is on high level ELD and grade-level core curriculum using SDAIE strategies; and

(c) Classes must be taught by a teacher with a CLAD credential or equivalent certification.

Section I – Teaching and Assessing California's English Language Development (ELD) and English Language Arts (ELA) Standards for English Learners

A document provided by West Ed, Northern California Comprehensive Assistance Center, 2000, reformats the State of California's English Language Arts (ELA) standards with those for English Language Development (ELD). The intent is for English Language students to acquire the standards established for language development to become proficient with the English Language Arts skills for reading, writing, listening and speaking. It is further proposed that one document could be provided to cluster standards from both ELA and ELD requirements with a single assessment. The assessment instrument would be helpful to identify students who are English learners, to provide information for instructional decisions, and to determine when reclassification is appropriate.

This paradigm shift promotes current thinking for competent language proficiency for all students. Rather than using language arts standards from an earlier grade level, the ELD standards follow a research-based progression from beginning to advanced language skills, and provide intermediate skills that ELD students need. Additionally the shift for future development is away from isolated use of ELD instruments toward the use of assessments representative of ELA standards.

English Language Proficiency Assessments for California (ELPAC)

School districts in California are required under federal and state laws to administer the ELPAC to determine English proficiency to students in kindergarten through grade twelve, whose primary language is not English. Students with exceptional needs who cannot take the entire ELPAC or a section of the test may be tested with special assistance and/or take alternate tests. All assistance or alternate tests must be documented in the student's IEP or Section 504 plan. The purpose of the ELPAC is to determine how well each student tested can listen, speak, read, and write English. ELPAC scores should be used annually in developing educational needs and appropriate goals in order to determine the level of assistance needed and to ensure the student's placement in an appropriate program.

A Map for Teaching and Assessing ELD and ELA Standards for English Learners

A map developed by West Ed, Northern California Comprehensive Assistance Center matches the standards for English Learner Development and for Language Arts Development in seven strands. Additionally it is divided into the academic areas of reading, writing, listening and speaking. They are available by grade span, (K-2, 3-5, 6-8, 9-10, and 11-12). A model that is generic for all grade level follows:

ELD Standards Alignment with ELA Standards

Reading

ELD Reading	*ELA Reading*
Word Analysis, Fluency and Systematic Vocabulary Development	Word Analysis, Fluency and Systematic Vocabulary Development
Reading Comprehension	Reading Comprehension, Expository Critique (grade 5 and up)
Literacy Response and Analysis	Literary Response and Analysis

Writing

ELD Writing	*ELA Writing*
Strategies and Applications	Strategies, Applications
Conventions	Written (and Oral) English Language Conventions

Listening and Speaking

ELD Listening and Speaking	*ELA Listening and Speaking*
Strategies and Applications	(Written and) Oral English Language Conventions

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA (CODE 3601)
DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA (CODE 3651)
17800 HIGHWAY 18 • APPLE VALLEY, CA 92307 • (760) 552-6700

☐ **Interim Placement**

STUDENT INFORMATION:

Last: _____ First: _____ Mid. Initial: _____ Suffix: _____

DOB: _____ Age: _____ Student No: _____ Gender: ☐ M ☐ F ☐ Non-Binary Grade: _____

Ethnicity: Select one only ☐ YES, Hispanic or Latino ***OR*** ☐ NO, not Hispanic or Latino Indicate one or more race(s) below:

(1) _____ (2) _____ (3) _____

Medi-Cal Eligible: ☐ Yes ☐ No Medi-Cal No.: _____ SSID No.: _____

Parent/Guardian/Surrogate: _____ Home Phone: _____

Address: _____ Work Phone: _____

Mailing Address: _____ Emg. Phone: _____

Contact Person (if student address different): _____ Contact Phone: _____

Student's Address (if different): _____ Residency Code: _____

LEA of Residence (Accountability): _____ School of Residence: _____

LEA of Service: _____ Attending School: _____

School Type Code: _____ Weekly % of Time the Student is in the General Education Setting: _____

Infant Setting (Ages 0-2): _____ Preschool Setting (Ages 3-5): _____ School Age Setting (Ages 6-22): _____

DISABILITY:

PRIMARY DISABILITY: _____

SECONDARY DISABILITY: _____

Check all that apply below and indicate the Primary and Secondary Disability Codes in the space provided above: (*Low Incidence)

☐ Intellectual Disability (210)	☐ Hard of Hearing (220)*	☐ Deafness (230)*	☐ Speech / Lang. Imp. (240)
☐ Visual Impairment (250)*	☐ Emotional Disturbance (260)	☐ Orthopedic Impairment (270)*	☐ Other Health Imp. (280)
☐ Est. Med. Disability (281)	☐ Spec. Learning Disability (290)	☐ Deaf / Blindness (300)*	☐ Multiple Disabilities (310)
☐ Autism (320)	☐ Traumatic Brain Injury (330)		

DATE: _____

TIMELINE INFORMATION (DATES)

Please mark the appropriate box and complete all information as they relate to the child.

☐ CHECK HERE IF INFANT (AGE 0-2) ☐ CHECK HERE IF CHILD IS AGE 3-22

Pre-referral Intervention w/in last 2 Years: ☐ Yes ☐ No

Referred by for Initial Assessment: _____

Date LEA Received Initial Signed AP: _____

Initial Referral Date: _____ Initial IEP Meeting Date: _____

If assessment not completed prior to student's 3rd birthday, specify Code No.: _____

If assessment not completed within 60-day timeline, specify Code No.: _____

Low Incidence Disability: ☐ Yes ☐ No Disability Code: ☐ 220 ☐ 230 ☐ 250 ☐ 270 ☐ 300

Original S.E. Entry Date: _____ S.E. Re-entry Date: _____

Exit S.E. Date: _____ Exit S.E. Code: _____

Current Annual Date: _____ Next Annual Review Date: _____

Annual Delay Date: _____ Reason for Delay: _____

Current Triennial Date: _____ Next Triennial Date: _____

Triennial Delay Date: _____ Reason for Delay: _____

Early Start Transition Plan Meeting Date: _____ Home Language Code: _____

English Language Learner: ☐ Yes ☐ No Reclassified: ☐

Migrant: ☐ Yes ☐ No Extended School Year: ☐ Yes ☐ No No. of Days: _____

Agency Services: ☐ CCS ☐ Rehab ☐ CARE ☐ Reg. Ctr. ☐ Other: _____

☐ Severe Disability ☐ Non-severe Disability ☐ Solely Low Incidence Disability (0-2 Years Only)

GRADUATION INFORMATION

Participate in High School Curriculum to Graduate with a Diploma ☐ Yes ☐ No

High School Program Leading to a Certificate of Completion ☐ Yes ☐ No

SPECIAL TRANSPORTATION INFORMATION

Check if student requires special transportation arrangements to participate in special education services.

☐ Eligible (indicate type and provider) ☐ Eligible – Parent Declined ☐ Not Eligible

Type: _____

Provider: _____

REASON FOR DECISION / ELIGIBILITY STATEMENT:

Student Name: _____ DOB: _____ Date: _____

SPECIAL EDUCATION AND RELATED SERVICES / OFFER OF FAPE

SPECIAL EDUCATION AND RELATED SERVICES

	SERVICE (CODE NO.)**		CLASS NO.	PROVIDER	LOCATION OF SERVICE (CODE NO.)	PROJECTED START DATE	FREQUENCY (CODE NO.)	DURATION (MINUTES PER FREQUENCY)
Primary		☐ Indiv. ☐ Group						
2		☐ Indiv. ☐ Group						
3		☐ Indiv. ☐ Group						
4		☐ Indiv. ☐ Group						
5		☐ Indiv. ☐ Group						
6		☐ Indiv. ☐ Group						
7		☐ Indiv. ☐ Group						
8		☐ Indiv. ☐ Group						
9		☐ Indiv. ☐ Group						
10		☐ Indiv. ☐ Group						
11		☐ Indiv. ☐ Group						
12		☐ Indiv. ☐ Group						
13		☐ Indiv. ☐ Group						
14		☐ Indiv. ☐ Group						
15		☐ Indiv. ☐ Group						
16		☐ Indiv. ☐ Group						
17		☐ Indiv. ☐ Group						
18		☐ Indiv. ☐ Group						

** NOTE: Programs and services will be provided according to where the student is in attendance and consistent with the LEA of service calendar and scheduled services, excluding holidays, vacations, and non-instructional days unless otherwise specified.

COMMENTS:

OFFER OF FREE APPROPRIATE PUBLIC EDUCATION (FAPE)

OFFER OF FAPE:

Student Name: _____ **DOB:** _____ **Date:** _____

INTERIM PLACEMENT

INDIVIDUALIZED EDUCATION PROGRAM INCLUDES:

- ☐ Assistive Technology (AT)
- ☐ Assistive Technology (AT) for Low Incidence Disability
- ☐ Behavior Intervention Plan (BIP)
- ☐ Health Care Plan
- ☐ Transition Plan (Age 15+)
- ☐ Other: _____
- ☐ Transportation
- ☐ Extended School Year

Whenever a pupil transfers into a district from a district not operating programs under the same local plan in which he or she was last enrolled in a special education program within the same academic year, the local educational agency shall provide the pupil with a free appropriate public education, including services comparable to those described in the previously approved individualized education program, in consultation with the parents to the extent possible within existing resources, for a period not to exceed 30 days, by which time the local education agency shall adopt the previously approved individualized education program or shall develop, adopt, and implement a new individualized education program that is consistent with federal and state law. EC 56325

- ☐ New to LEA from within the Desert/Mountain SELPA/Charter SELPA — 30 Day Review Date: _____
- ☐ New to LEA from outside of the Desert/Mountain SELPA/Charter SELPA — LEA Name: _____ — 30 Day Review Date: _____
- ☐ New to LEA from outside the State of California — 30 Day Review Date: _____

COUNTY OPERATED PROGRAMS

When a student moves into a LEA and has an IEP requiring supports and services that are unable to be provided by the LEA, the LEA can make an interim placement into a county program operated by Desert/Mountain Operations.

☐ Referral to Desert/Mountain Operations (The LEA special education administrator/designee must complete the SELPA Interim Placement Form and Form D/M 85)

RESIDENTIAL NONPUBLIC SERVICES

Residential nonpublic school provision applies to this student: ☐ Yes ☐ No

Note: *For a pupil placed and residing in a residential NPS prior to transferring to a school district in another special education local plan area, and this placement is not eligible for funding pursuant to Section 56836.16, the special education local plan area that contains the district that made the residential NPS placement shall continue to be responsible for the funding of the placement, including related services, for the remainder of the school year. An extended year session is included in the school year in which the session ends. EC 56325 (c)*

ADOPTION OF PREVIOUS INDIVIDUALIZED EDUCATION PROGRAM

Adopt current IEP:

☐ Yes ☐ No (Schedule an Addendum)

COMMENTS/NOTES:

METHODS OF CONSULT WITH PARENT/GUARDIAN/SURROGATE:

☐ IN PERSON ☐ PHONE CONFERENCE ☐ VIRTUAL ☐ EMAIL ☐ WRITTEN CORRESPONDENCE Date of Consultation: _____

Administrator/Case Manager Name: _____ Title/Position: _____

Introduction

In 1996, the United States Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was designed to accomplish a number of objectives, one of which is to protect the privacy of individually identifiable health information. Protection standards exist for protected health information (PHI) in all forms, including electronic formats (ePHI).

The standards set forth by HIPAA apply to "covered entities," including health care providers and the agencies they work within. The Desert/Mountain Children's Center (DMCC) is a covered entity and is thus required to comply with the regulations specified by HIPAA. This manual details the policies and procedures established for the DMCC to ensure HIPAA compliance.

HIPAA Privacy and Security Plan

The HIPAA Act of 1996 and its implementing regulations restrict DMCC's abilities to use and disclose protected health information (PHI).

Protected Health Information. Protected health information is information that is created or received by the DMCC and relates to the past, present, or future physical or mental health condition of a Patient/Client ("Participant"); the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

Some examples of PHI are:

- Participant's chart record number
- Participant's demographic information (i.e., address, telephone number)
- Information clinicians, psychologists, and other health care providers put in a participant's clinical record
- Images of the participant
- Conversations a provider has about a participant's care or treatment with other staff
- Information about a participant in a provider's computer system or a health insurer's computer system
- Billing information about a participant at a clinic
- Any health information that can lead to the identity of an individual or the contents of the information can be used to make a reasonable assumption as to the identity of the individual

It is DMCC's policy to comply fully with HIPAA's requirements. To that end, all staff members who have access to PHI must comply with HIPAA Policies and Procedures (See Appendix A). For purposes of this plan and DMCC's use and disclosure procedures, the workforce includes individuals who would be considered part of the workforce under HIPAA such as employees, volunteers, student interns, board members, and other persons whose work performance is under the direct control of DMCC, whether or not they are paid by DMCC. The term "employee" or "staff member" includes all of these types of workers.

No third party rights (including but not limited to rights of participants, beneficiaries, covered dependents, or business associates) are intended to be created by this Plan. DMCC reserves the right to amend or change this plan at any time without notice.

All staff members must comply with all applicable HIPAA privacy and information security policies. If after an investigation a staff member is found to have violated the organization's HIPAA privacy and information security policies, then the staff member will be subject to disciplinary action up to termination or legal ramifications if the infraction requires it.

E-PHI

The federal HIPAA's Security Regulation requires mental health and other small health care practices to meet administrative, physical, and technical standards to protect the confidentiality, integrity, and accessibility of their Protected Health Information (ePHI). The Regulation is in large part intended to prevent computer hacking, identity theft-related crime, and similar issues posed by the use of electronic information technology in health care practices and to create a general "culture of security" in those practices.

The federal Health Information Technology for Economic and Clinical Health (HITECH) Act was passed as part of the American Recovery and Reinvestment Act of 2009 (ARRA) and it broadens the privacy and security protections under HIPAA. Specifically, HITECH requires covered entities to notify affected individuals and the Secretary of Health and Human Services (HHS) in the event of a breach of their "unsecured PHI". Many state laws impose similar or overlapping obligations on businesses.

Another significant change brought about by HITECH is that a covered entity's "business associates" (and their subcontractors) are now directly subject to HIPAA's Security Regulation. HITECH also broadened, (and in some cases, narrowed) the definition of "business associate". Thus, a practice's security program should require the practice to keep a closer eye on its business associate relationships, as discussed in greater detail below.

The HIPAA Final Rule released on January 17, 2013, amended HIPAA's privacy and security rules to implement the foregoing HITECH requirements. The definition of what constitutes a "breach" of PHI was also broadened by the Final Rule, which now requires a practice to "presume" that any non-permitted acquisition, access, use or disclosure of PHI is a breach under HIPAA requiring notification to affected individuals and HHS in accordance with HIPAA regulations. In determining whether a covered entity can overcome the presumption of a breach, the Final Rule requires covered entities to undergo a "risk assessment" based on several factors to determine whether there was a low probability that the PHI was compromised by the non-permitted acquisition, access, use or disclosure. The Final Rule also increased civil money penalties payable to HHS for uncorrected violations and willful neglect of HIPAA requirements.

HITECH and the Final Rule made few changes to the technical standards of the Security Regulation and a full analysis of HITECH and the Final Rule is therefore beyond the scope of this Manual. Nevertheless, in implementing and maintaining a security program, practices should be aware of the changes summarized above. Now more than ever, HHS is bringing enforcement

actions against providers and business associates for breaches of unsecured PHI. Given this heightened enforcement environment and the broadening of the privacy and security rules under HITECH and the Final Rule, practices are well advised to increase their focus and involvement in maintaining a strong security program consistent with the Security Regulation.

The Security Regulation applies only to electronic data used, transmitted, or maintained by the practice (unlike the HIPAA Privacy Regulation which covers health information on paper or in any other form). However, practitioners should remember that the Regulation's definition of electronic Protected Health Information includes demographic, health and financial information which might include name, address, social security number, credit card numbers, insurance plan numbers, or other identifiers.

The HIPAA Security Regulation is not highly specific. The Regulation essentially requires health care practices to take ***reasonable and appropriate*** measures to protect against ***reasonably anticipatable*** threats to the practice's ePHI. The Regulation sets a series of 18 standards for the protection of electronic health information and a total of 36 implementation specifications to help health care providers address what needs to be done to meet those standards. The HIPAA Security Regulation is outlined in the following pages with standards and implementation specifications.

Compliance with ***all*** standards is ***required.*** In most cases, compliance with the implementation specifications under a standard will constitute compliance with the standard. Implementation specifications are divided into ***required*** specifications that must be implemented exactly as indicated and ***addressable*** specifications which can be adapted in a manner reasonable and appropriate to the practice so as to address reasonably anticipatable risks to ePHI. However, the Centers for Medicare and Medicaid Services (CMS), the enforcement agency for the Regulation, emphasizes that "addressable" does not mean "optional". Should a practice not implement an addressable measure exactly as indicated, the practice must document alternative measures and the reason they were taken. **Compliance with all the standards and specifications must be documented.**

Section I: Descriptions and Definitions

Administrative Safeguards: Administrative safeguards refer to these policies and procedures used by the Desert/Mountain Children's Center (DMCC) to comply with HIPAA standards.

I. Security/Privacy Officer

The Director of the DMCC is the designated Security/Privacy Officer and is responsible for knowing HIPAA regulations, training the DMCC staff which includes, clinical staff (student interns, Intervention Specialists, Behavioral Health Counselor I, Behavioral Health Counselor II, Clinical Counselors and Behavioral Health Counselor Supervisors), administrative staff, and support staff (business, clerical, and student workers) in HIPAA compliance, and assuring that HIPAA related policies and procedures are instituted and followed. The Security/Privacy Officer will:

- Update HIPAA policies and procedures
- Oversee the implementation of the policies and procedures contained in this Manual
- Ensure that all clinic personnel are trained regarding HIPAA and the policies and procedures of the clinic on an annual basis
- Review activity that takes place in the clinic to detect security risks
- Investigate and respond to security incidents and take appropriate action in the event of a breach in security, and eliminate or mitigate any damaging effects.

II. Training Program

All clinic personnel are required to participate in a formal HIPAA training program. The training program was instituted at DMCC in the fall of 2007, and all existing personnel were required to complete the training. All new employees receive the training within 30 days of their employment with DMCC.

The training involves attending the HIPAA Training for covered Entities, and signing the Employee Agreement for both HIPAA and the Omnibus rules. Additionally, this Manual is available to all DMCC personnel through the web-based Live Binder. It is also available as a hard copy in the clinic office.

III. Documentation of Training

Training of DMCC personnel will be recorded in an electronic HIPAA Training Log.

IV. HIPAA Notification

All clients who receive DMCC services are given a *HIPAA Notice of Privacy Practices (NOPP)* document before their first session. They sign a document indicating they

have received the Notification. Additionally, a HIPAA Notification document is posted in the waiting room of the clinic.

V. Release of Information

Client PHI is only released to another party when the release is requested, in writing, by the client or the client's legal guardian. The *Release of Health Information* form is completed when a request is made.

The exceptions to the release of PHI without a signed release of information occurs only in accordance with strict policies (i.e., harm to self and/or others).

Ensuring Disclosures are the Minimum Necessary

When a request is received to disclose PHI, the request is reviewed by a DMCC program manager. The document will clearly state what is to be released and the minimum will be disclosed. The principle guiding the release of PHI is to limit disclosure of information not reasonably necessary to accomplish the purpose for which the request is made.

Accounting for Disclosures

The DMCC support staff will identify in its database, per child any disclosures to external agencies whenever a release of information is requested by a client.

Request for File Review and Copy

Clients and/or legal guardians of clients, who have records with the DMCC may request to inspect and obtain a copy of their PHI in the "designated record set," defined as the medical and billing records maintained by the clinic and used to make decisions about the client. The request must be made in writing, and will be fulfilled within 30 days of receipt. HIPAA does not allow clients to have access to their therapist's psychotherapy notes.

Requests to Amend a Record

Clients and/or legal guardians of clients, have the right to amend their record if they believe the record is incomplete or not accurate. The amendment will become part of their ongoing file. Requests for record amendments must be made in writing. Clients may not expunge any prior information or part of the Record.

VI. Security Assessment and Reporting

The DMCC Director will engage in a yearly assessment of the clinic's adherence to the policies detailed in this manual. As part of the annual facility assessment, teams

consisting of administrative staff and clinicians will be asked to conduct an assessment of any potential security problems and to recommend additional security measures.

Reporting of Security Violations

DMCC personnel are required to report any violations of HIPAA standards to the Security/Privacy Officer.

Responding to Violations and Preventing Further Violations

When security incidents or deficiencies are reported or discovered, the Security/Privacy Officer will investigate the situation and complete the *HITECH Act Breach Notification Risk Assessment Tool* (see Appendix B). The breach tool will contain any corrective measures as needed. Corrective measure may include personnel re-education, policy revision, building modification, and/or equipment alterations.

VII. Policies and Procedures to Access Protected Health Information

Access to PHI is limited to DMCC personnel and business associates and further restricted to the information needed by personnel to complete a job function and/or clinical training.

VIII. Business Associates

"Business associates" are defined by HIPAA as third parties who provide services to DMCC and may have access to electronic patient health information. The DMCC currently has business associate agreements. In the event DMCC enters into an additional arrangement with a business associate, a Business Associate Agreement will be adopted and utilized.

IX. Research Activities

Client information may not be used for research or marketing purposes unless the client has agreed to allow his/her PHI to be used in this manner. All research projects must also be approved by the CAHELP Institutional Review Board.

X. Clinic Visitors

Occasionally visitors tour the DMCC facility as they are learning to create their own programs. All visitors must be escorted by DMCC personnel who ensure PHI is not disclosed or visible.

Section II: Physical Safeguards

Physical safeguards refer to the processes in place in which DMCC controls physical access to protected information.

Building Access

Access to the DMCC, with the exception of the lobby is limited to DMCC personnel who are given a key(s) to the building and are required to wear their identification badge to enter into the treatment rooms and/or administrative staff area. Keys are dispersed by the Operations Officer of the CAHELP who maintains a record of key distribution and a signed document from the employee of receipt of the key(s). Upon termination, DMCC administrative staff will collect the key(s) from the employee and return it to the Operations Officer of CAHELP.

Mailboxes

Written communication pertaining to DMCC and clinical work is distributed via personnel mailboxes housed within DMCC offices. These mailboxes are kept behind locked doors.

Session Recordings

Recordings are made of certain sessions with the permission of the client and/or guardian of the client depending on the type of treatment they are receiving (i.e., Parent-Child Interaction Therapy – PCIT, Theraplay, etc.). Recordings are digitized and maintained in a locked file. The recordings are not allowed to leave the premises. Recordings are only to be utilized for the purpose as clearly identified on the permission to record document.

Documentation

Session notes are recorded in Athena Software (Penelope) and Netsmart myEvolv, both secure electronic medical records system. Report copies may also be kept in the client files.

Document Retention

Electronic medical records on Penelope and myEvolv are maintained indefinitely in this secure medium. Any client paper files are maintained in a file cabinet that is open during business hours and locked thereafter. The room holding client files is locked after hours as well. Any files maintained are housed in locked cabinets behind two sets of locked doors when DMCC is not open for business. Paper files of terminated clients are scanned in Penelope and/or myEvolv and stored at a secured facility.

Section III: Technical Safeguards

Technical safeguards refer to the procedures in place to control access and/or interception to computer systems and to protect all communications containing PHI transmitted electronically.

Electronic Medical Records System (Penelope)

DMCC uses both Penelope and myEvolv software, electronic medical records systems designed specifically for counseling centers and psychology training clinics. Penelope and myEvolv may only be accessed by DMCC personnel, each of which has a unique user name and password. Access is restricted by safety measures in the system that restrict users from being able to view records of clients who are not their own. Once files are saved they cannot be changed or erased without a clear electronic tracking of any activity and clear identification of who accessed records. Full access to Penelope is granted only to limited staff including the administrative staff, support staff and technology personnel to maintain the program.

Computer Workstations

All computer access is secure from clients, parents and/or visitors to the DMCC. The reception area computer (which is behind glass and locked doors) is turned off each day after business hours. All DMCC personnel log off of Penelope and documents before leaving them unattended. Documents are kept, completed and maintained in Penelope through the network server and/or client hard files.

Mobile Devices

All organizationally purchased mobile devices used by the DMCC staff have a Mobile Device Management (MDM) application installed on them that allows for remote management and wiping of the device if it is lost or stolen.

Computer Flash Drive

The use of flash drives or portable electronic media to store ePHI data is prohibited.

Cloud Storage

The use of cloud storage to store ePHI is allowed when it is a DMCC approved HIPAA compliant cloud storage.

Faxing

The fax machine at DMCC is housed in a locked area of the clinic. The fax machine is checked throughout the day to ensure faxed documents are not left unattended.
If faxing, only the PHI needed is sent, and a cover letter with a confidentiality statement accompanies the information to help prevent casual reading. Additionally, frequently used fax numbers are programmed into the machine to ensure accuracy in dialing. New fax numbers are verified before PHI is transmitted. The machine does not have the capacity to save copies of faxed information.

Email

DMCC uses an encrypted email solution when emailing client PHI information to entities outside of the network. The encryption process is accomplished with software on our email gateway server. All DMCC personnel have been trained to use "Encrypt" on the subject line to ensure proper encryption. Client level information is attached with a privacy statement in the body of the email. Privacy notices on all emails is appended as part of the sending process and is enforced from the system.

Telephone

Phone calls are made to clients and/or guardians from the office area for routine appointment reminders and appointment clarification. The office area is behind locked doors and a glass partition. All information occurs away from all clients, guardians, and visitors.

Electronic Health Records Policy and Procedures

Electronic Health Records (EHR) complies with HIPAA, and all state and federal laws related to protection of personal health information. EHRs can be encrypted (making the document(s) unreadable to anyone other than an authorized user) and security access parameters set to only authorized individuals can view them. EHRs also offer the added security of an electronic tracking system that provides an accounting of the history of when records have been accessed and by whom.

General Information

System users who send, receive, store and access ePHI must comply with DMCC's Electronic Health Records Policy and Procedures.

I. Policy

DMCC provides physical attributes required to protect information systems and related infrastructure from unauthorized access in accordance with HIPAA Security Rules to protect the availability, confidentiality, and integrity of client and departmental confidential information.

DMCC personnel are responsible for maintaining the physical security of DMCC's computer resources under their control. They are also responsible for protecting the integrity and privacy of the data maintained on the computer by using appropriate lockdown devices, password controlled access, data encryption, virus protection software, and routine backup procedures.

DMCC is under the umbrella of the California Association of Health and Education Linked Professions (CAHELP), which is a department of San Bernardino County Superintendent of Schools (SBCSS). SBCSS, CAHELP, and DMCC reserve the right to inspect all data and to monitor the use of all its computer systems.

All computer users have no right to privacy with regard to information on organizationally supplied computers. Personnel are not allowed to place any client information (ePHI) on personally owned technology devices. The organization reserves the right to remotely access, monitor, control, and configure organizationally-supplied computers and any software residing on said device. Non-compliance with this policy is subject to management review and action up to and including termination of employment, vendor contract, and/or legal action.

- All computers are equipped with updated software for detecting the presence of malicious software (i.e., computer viruses). All computing devices have current versions of anti-virus software enabled. Operating systems have all critical updates installed.
- All computers are positioned or located in a manner that minimizes the exposure of displayed patient and/or sensitive business information.

- DMCC personnel accessing the DMCC network or information from remote locations are trained to utilize appropriate security safeguards.
- DMCC through the CAHELP and with SBCSS's direction and approval shall have the in ability to recommend and implement hardware, operating systems, and connectivity solutions to be supported. System support of any proposed solutions will need to be included in the purchasing decision.
- DMCC personnel may not independently install hardware or software solutions that allow remote access to organizationally-purchased devices.
- DMCC personnel must comply with DMCC's policies and state and federal laws and regulations regarding the proper acquisition, use and copying of copyrighted software and commercial software licenses.

II. PURPOSE

The DMCC is committed and required to provide security to protect its computerized clinical and business information systems. DMCC computer system hardware and software as well as the information and data carried by the system are the property of the CAHELP/SBCSS. Any misuse of DMCC computers may result in denial of access to the system network and systems, DMCC information, and data. The intent of this policy is to:

- Ensure each system containing ePHI has the necessary access controls to restrict unauthorized users and programs from accessing patient health or sensitive business information.
- Ensure software on each computer on the network is internally compatible and will not lead to degradation of the system.
- Ensure users are oriented and trained on computer use and maintenance of information integrity, privacy, and resource security.
- Establish security requirements for the appropriate use of mobile computing resources including laptops and mobile computing devices that access DMCC information or interface with the DMCC network.

III. SCOPE

This policy applies to all DMCC personnel, vendors, contractors, and business associates who have access to DMCC client information, either clinical and/or business related, stored on DMCC computers or have access to its computer resources or network. The scope of this policy includes the usage of all and any device that directly or remotely accesses the DMCC network.

IV. DEFINITION

Portable-Computer Device: A portable-computing device is a computer that is easily transported by hand and has the ability to store DMCC client and/or business information. "Portable computing device" generally refers to laptop computers, smart clipboards, and mobile computing devices but can include other emerging technologies

that allow storage of and access to information, and are capable of connection (physical or wireless) to the computer network, including connection to any server or computer on the computer network.

V. PROCEDURES

General

1. Users are required to log-off of applications containing client health and/or sensitive business information before leaving their computers.
2. Users must save work that contains ePHI in accordance with approved data storage policies.
3. All laptops and any other portable computer equipment must be secured (protected) when not in use.
4. Storing ePHI information on ANY Device that is not encrypted is prohibited.
5. Storing of PHI information on a personal device is prohibited.
6. Employees are responsible for breaches of security related to devices in their possession.
7. All computers require a complex-level password protection with the computer system. In order to access any client health and/or business information, a second level of authentication protection is required to access information.
8. There are no circumstances when security provisions are allowed to be disabled.
9. DMCC personnel are required to have appropriate clearance prior to access to computers and the Penelope network.
10. Upon termination or change of job position, users will have network access removed or modified as deemed appropriate by administration.
11. All computer devices shall be tagged and tracked by administration in accordance with SBCSS's asset management policies and procedures.

Desktop Computers

DMCC has established standard configurations for desktop technologies deployed throughout the organization. All computers, computer peripherals, and software as well as printers, faxes, and other miscellaneous hardware purchased with DMCC funds or attached to any component of the DMCC network must meet these standards.

Installation of any personal software, whether purchased or downloaded, by employees is prohibited. Software required for end user productivity must be approved by the Director and installed by CAHELP/SBCSS helpdesk staff.

Desktop computers are located in areas that are physically separate and face away from the public.

Computer access and password training provided by the DMCC administrative staff must be completed prior to granting access privileges to ensure adequate training has occurred.

Desktop computers are equipped with security hardware and/or software. Computers **must** comply with all software updates for detecting the presence of malicious software. All devices will have current versions of anti-virus software enabled. Operating systems will have all critical updates installed.

Mobile devices that store ePHI will be secured using compliant measures.

Organizationally-Supplied Portable/Mobile Computer Devices

The loss or theft of any portable computer device storing DMCC client and/or sensitive business information shall be immediately reported to the employee's supervisor. The supervisor will contact the DMCC Security/Privacy Officer.
Startup authentication and authorization passwords (user name and password) are required on all computers. Storing or caching username and passwords on any device is prohibited.

Organizationally-supplied portable computer devices storing data belonging to the DMCC may not be shared with others, especially non-employees, who are not authorized to access the information unless the information is stored as encrypted password protected files.

DMCC reserves the right to identify sensitive information and initiate methods to secure this information.

Personally-Supplied Portable/Mobile Computer Devices

The use of personally-supplied devices by DMCC/CAHELP personnel in support of the organization's mission or work is strictly prohibited.

Remote Access

Access to DMCC's internal remote location will be done through appropriate Virtual Private Network (VPN) services and must be approved by the Security/Privacy Officer.

Access to DMCC's internal network from outside of its defined network perimeter will be controlled by VPN access controls that may only be established by technical staff.

Users are not authorized to install hardware or software solutions that would allow remote access to their organizationally-supplied computing devices.

VPN connections will be strictly controlled, implemented, and maintained by SBCSS technical staff.

VI. Staff Use of System and Privileges

Monitoring of computer use

Personnel utilizing DMCC systems should have no expectation of privacy. The DMCC will log, review, or monitor any data stored or transmitted on its information systems to manage those assets to ensure compliance with the agency's policies.

Removal of staff privileges

The DMCC may remove or deactivate any employee's network privileges, including but not limited to, user access accounts and access to secured areas, when necessary to preserve the integrity, confidentiality and availability of its facilities, user services, and data.

System Security

Each computing device used to access, transmit, receive, or store ePHI must comply with DMCC policies. If any policy requirement is not supported by the workstation operating system or system architecture, one of the following steps must be taken:

- The system must be upgraded to support all of the following security measures
- An alternative security measure must be implemented and documented
- The computer must not be used to send, receive, or store ePHI

VII. Data Maintenance and Emergency Procedures

Server

Since 2007, private health information at the DMCC that is ePHI is maintained by an Electronic Medical Records System (Penelope). Penelope is a cloud-based system that provides for redundancy and disaster recovery solutions. The data sheet for Penelope can be found at:

http://www.athenasoftware.net/resources/Penelope_PRIVACY_AND_SECURITY_Whitepaper_2014.pdf

Since March 2020, private health information at the DMCC that is ePHI is maintained by an Electronic Medical Records System (Netsmart myEvolv). myEvolv is a cloud-based system that provides for redundancy and disaster recovery solutions. The data sheet for myEvolv can be found in Appendix D.

Technical staff are responsible to ensure all servers used to access, transmit, receive or store ePHI are appropriately secured with this policy.

1. Server Location

DMCC in-house (non-cloud) servers currently reside at a secure facility. All data not stored in the cloud solution is stored on these systems.

- Servers are located in a physically-secure environment
- The system administrator account is password protected
- A user identification and password authentication mechanism is implemented to control user access to the system
- A security patch and update procedure is established and implemented to ensure all relevant security patches and updates are promptly applied based on the severity of the vulnerability corrected
- Servers are located on a secure network with firewall protection
- All unused or unnecessary services are disabled

2. Computer Security

Technical staff are responsible to ensure each computer system used to access, transmit, receive, or store ePHI is appropriately secured in accordance with this policy. A user identification and password authentication mechanism is implemented to control user access to the system.

- All users must be issued a unique user name for accessing PII
- Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, within 24 hours
- Passwords are not to be shared
- Passwords must be at least eight characters and complex
- Passwords must not be cached
- Passwords must be changed every 180 days.
- Passwords must be changed if revealed or compromised.
- Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:
  - Upper case letters (A-Z)
  - Lower case letters (a-z)
  - Arabic numerals (0-9)
  - Non-alphanumeric characters (punctuation symbols)
- A security patch and update procedure is established and implemented to ensure all relevant security patches and updates are promptly applied based on the severity of the vulnerability corrected: All computers and devices that process and/or store PII must have critical security patches applied including those patches that require a system reboot. The patch management process determines installation timeframe based on risk assessment and vendor recommendations. All applicable patches deemed as high risk must be installed as soon as practical. Applications and systems unable to be patched within this time frame, due to significant operational reasons, must have compensatory controls implemented to minimize risk.

- A malware detection system is implemented including a procedure to ensure the detection software is maintained and up-to-date
- All unused or unnecessary services are disabled
- An automatic logoff or inactivity timeout mechanism is implemented
- The computer screen or display must be situated in a manner that prohibits unauthorized viewing. The use of a screen guard or privacy screen may be used
- Laptop devices will have hardware level disk encryption
- **Data Destruction:** When an electronic storage device that contains PII is sent for destruction, it is erased using the US Department of Defense clearing and sanitizing standard DoD 5220.22-M or equivalent
- **System Timeout:** The system providing access to PII must provide an automatic timeout, requiring re-authentication of the user session after no more than 30 minutes of activity
- **System Logging:** The system maintains an automated audit trail that can identify the user or system process, initiates a request for PII, or alters PII. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If PII is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three years after occurrence
- **Access Controls:** The system providing access to PII must use role based access controls for all user authentications, enforcing the principle of least privilege
- **Transmission Encryption:** All data transmission of PII outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm that is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PII can be encrypted. This requirement pertains to any type of PII in motion such as website access, file transfer, and email
- **Intrusion Detection:** All systems involved in accessing, holding, transporting, and protecting PII, which are accessible through the Internet, must be protected by a comprehensive intrusion detection and prevention solution

3. Logoff Procedures

To ensure security to all servers and computers accessing, transmitting, receiving, and/or ePHI, the following procedures must be followed:

Automatic Logoff Procedures

- Servers, computers and other electronic devices containing ePHI must employ inactivity timers or automatic logoff mechanisms
- Servers, computers and other electronic devices containing ePHI must terminate a user session after a maximum of, but not limited to, 30 minutes of inactivity

- When a system requires the use of an inactivity timer or automatic logoff mechanism but does not support an inactivity timer or automatic logoff mechanism, one of the following procedures must be implemented:
  - The system must be upgraded to support the minimum HIPAA Security
  - The system must be moved into a secure environment
  - ePHI must be removed and relocated to a system supporting the minimum requirements

Logging off the System

When a server, computer, or other electronic device is unattended users must lock or activate the systems Automatic Logoff Mechanism (e.g., CTRL, ALT, DELETE and Lock computer), or logout of all applications and database systems containing confidential information.

Network and Privacy Settings

Schedule for Backups

Backups are scheduled nightly and are encrypted to offsite, encrypted storage. Backups are maintained for a two-week period.

Recovery Plan for Data

On premises servers are backed up regularly using VM-level backups. Servers and data can restore all data necessary to the version from the night before. There is also a database-level backup of Penelope data that is performed daily. Details for back and recovery for clouds servers can be found in (See Appendix C).

Security Protocols for Access to Data

Password resets are in effect every 180 days for all users.

Encryption security level

- Computers and server storage is encrypted where necessary
- Intra site communication is direct and secure so no special encryption is necessary.

Firewalls

The DMCC has firewalls installed at internet connection points at the primary datacenter and disaster recovery datacenter. Firewalls are maintained and patched by a firewall vendor. Inbound access is analyzed using an IPS/IDS, Intrusion Prevention Systems and Intrusion Detection system, device which scans all inbound and outbound traffic for malicious attacks. Both datacenters are secured

and access is controlled with the use of a key card access system. Only authorized personnel are permitted to access our datacenters. The primary data center power is protected using a natural gas generator and halon fire suppression system.

Remote Access

Access from outside of DMCC is available only through approved VPN secured connections with encrypted and physical security checks.

VIII. Electronically-Signed Records

For the purpose of this policy an electronically signed record is a financial, program, or medical record that (1) is required to be signed under California or Federal law, California or Federal regulation, or organizational policy or procedure, and (2) may be requested during an audit.

Standards for Electronic Signatures in Electronically Signed Records

Electronic signatures in electronically-signed records will be viewed as equivalent to a manual signature affixed by hand for financial, program, and medical records for audit purposes as defined under the California Code of Regulations, Title 9.

DMCC's policy for electronic signature meets the following requirements:

1. DMCC's computer system (Penelope and myEvolv) utilizes electronic signatures that comply with the following Certification Commission for Healthcare Information Technology (CCHIT) certification criteria or equivalent: *Security: Access Control, Security: Audit, and Security: Authentication.*
2. The electronic signature mechanism is (a) unique to the signer, (b) under the signer's sole control, (c) capable of being verified, and (d) linked to the data so that, if the data are changed, the signature is invalidated. Additionally, DMCC will maintain physical signatures for all clinical staff on file as backup.
3. DMCC will maintain an Electronic Signature Agreement for the terms of use of an electronic signature signed by both the individual requesting electronic signature authorization and the county mental health director or his/her designee.
4. DMCC will request and maintain an Electronic Signature Certification from entities where contracts are held through the Department of Behavioral Health where such is required.
5. The signed *Electronic Signature Certification* and signed *Electronic Signature Agreements* forms will be available to the auditor at the time of an audit.

Information Security Considerations

DMCC's standard encryption of data is also employed in the electronically-signed record.

Obtaining Consumer Signatures

In many situations, the mental health consumer, or his/her representative, must acknowledge his/her willingness to participate in and accept the treatment plan. In paper-based systems, the consumer, or his/her representative, physically signs a document to that effect. As an alternative to paper, it is DMCC's policy the following approaches will be utilized: (1) scanning paper consent documents, treatment plans, or other medical record documents containing consumer signatures or (2) capturing signature images from a signature pad.

DMCC will maintain all information and will be in full compliance with all applicable HIPAA electronic signature standards. Upon future publication of HIPAA electronic signature regulations, the DMCC will be in full compliance within the timelines and all requirements established by state and federal government.

Requirements for Electronically-Signed Records

The DMCC will utilize electronic records and electronically-signed records to replace all paper-based records for purposes of an audit. When an audit is conducted, the DMCC shall make available the following upon arrival of the auditor at the audit site:

- Physical access to electronic health record systems
- Adequate computer access to the electronic health records needed for the audit review
- System or network access to electronic records such as user IDs and passwords
- Access to printers and capability to print necessary documents
- Technical assistance as requested
- Scanned documents, if needed, which are readable and complete

PHI – Personal Health Information

PHI and PII Use and Disclosure

PHI Definition and Data Elements

Below is an excerpt from the U.S. Department of Health & Human Services defining PHI and PHI data elements:

Protected Health Information: The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information *protected health information* (PHI).

Individually identifiable health information is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual,
- The individual's identity or for which there is a reasonable basis to believe it can be used to identify the individual

Individually identifiable health information includes many common identifiers (i.e., name, address, birth date, Social Security Number) and generally encompasses all PII (see below). All PHI is protected by both HIPAA and ethical standards.

PII Definition and Data Elements

Per the Executive Office of the President, Office of Management and Budget (OMB) and the U.S. Department of Commerce, Office of the Chief Information Officer, The term *personally identifiable information* refers to information that can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc." Any information that is personal is protected by privacy laws.

California Senate Bill SB 1386: *personal information* means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted:

1. Social Security Number
2. Driver's license number or California Identification Care number
3. Account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account

Use and Disclosure Defined

The DMCC will use and disclose PHI only as permitted under HIPAA. The terms "use" and "disclosure" are defined as follows:

- *Use* – The sharing, employment, application, utilization, examination, or analysis of individually identifiable health information by any person working for or within the company, or by a business associate of the company
- *Disclosure* – for information that is protected health information, disclosure means any release, transfer, provision of access to, or divulging in any other manner of individually identifiable health information to persons not employed by or working within DMCC with a business "need to know" PHI

Access to PHI is Limited to Certain Employees

All personnel who perform Participant functions directly on behalf of the DMCC or on behalf of group health plans will have access to PHI as determined by their supervisor, job description, and as granted by IT. These employees with access may use and disclose PHI as required under HIPAA but the PHI disclosed is limited to the minimum amount necessary to perform the job function. Employees with access may not disclose PHI unless an approved compliant authorization is in place or the disclosure otherwise is in compliance with this Plan and the use and disclosure procedures of HIPAA.

Personnel may not access either through the information systems or the participant's medical record the medical and/or demographic information for themselves, family members, friends, staff members, or other individuals for personal or other non-work-related purposes, even if written or oral participant authorization has been given. If the employee is a participant in DMCC's plans, the employee must go through their provider in order to request their own PHI.

In the very rare circumstance when an employee's job requires him/her to access and/or copy the medical information of a family member, a staff member, or other personally known individual, then he/she will immediately report the situation to his/her supervisor who will assign a different staff member to complete the task involving the specific participant.

Personal access to your own PHI is based on the same procedures available to other participants not based on job-related access to our information systems. For example, if you are waiting for a lab result or want to view a clinic note or operative report, you must either contact your provider for the information or make a written request to the Security/Privacy Officer. Employees may not access their own information; they must go through all the appropriate channels as participants are required to do.

Disclosure of PHI Pursuant to an Authorization

PHI may be disclosed for any purpose if an authorization satisfying HIPAA requirements for a valid authorization is provided by the participant. All uses and disclosures made pursuant to a signed authorization must be consistent with the terms and conditions of the authorization.

Permissive Disclosures of PHI: For Legal and Public Policy Purposes

PHI may be disclosed in the following situations without a participant's authorization, when specific requirements are satisfied. DMCC's use and disclosure procedures describe specific requirements that must be met before these types of disclosures may be made. Permitted are disclosures:

- About victims-of-abuse, neglect or domestic violence;
- For judicial and administrative proceedings – with appropriate subpoenas;
- For law enforcement purposes;
- For certain limited research purposes;
- To avert a serious threat to health or safety;
- For specialized government functions; and
- That relate to workers' compensation programs.

Complying with the "Minimum-Necessary" Standard

HIPAA requires when PHI is used or disclosed, the amount disclosed generally must be limited to the "minimum-necessary" to accomplish the purpose of the use or disclosure. The "minimum-necessary" standard does not apply to any of the following:

- Uses or disclosures made to the individual;
- Uses or disclosures made pursuant to a valid authorization;
- Disclosures made to the Department of Labor;
- Uses or disclosures required by law; and
- Uses or disclosures required to comply with HIPAA.

Minimum-Necessary When Disclosing PHI

For making disclosures of PHI to any business associate or providers, or internal/external auditing purposes, only the minimum-necessary amount of information will be disclosed. All other disclosures must be reviewed on an individual basis with the Security/Privacy Officer to ensure the amount of information disclosed is the minimum necessary to accomplish the purpose of the disclosure.

Minimum-Necessary When Requesting PHI

For making request for disclosure of PHI from business associates, providers, or participants for the purposes of claims payment/adjudication or internal/external auditing purposes, only the minimum necessary amount of information will be requested.

All other requests must be reviewed on an individual basis with the Security/Privacy Officer to ensure the amount of information requested is the minimum necessary to accomplish the purpose of the disclosure.

Protected Health Information (PHI): Patient information, including demographic information, that:

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present, or future physical or mental health condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient; and
- Identifies the patient or can be used to identify a patient.

Lobby Interactions

DMCC personnel are not to reveal PHI in the lobby with clients. DMCC personnel will ask clients and/or parents to step into a confidential, private office to conduct conversations related to PHI.

Consequences of Violations

Personnel violations of DMCC systems as described above will be subject to disciplinary action that may include termination of employment.

Disclosure of PHI to Business Associates

Based on the approval of the Security/Privacy Officer and in compliance with HIPAA, employees may disclose PHI to the company's business associates and allow the DMCC's business associates to create or receive PHI on its behalf. However, prior to doing so, the DMCC must obtain assurances from the business associate agreeing to appropriately safeguard the information. Before sharing PHI with outside consultants or contractors who meet the definition of "business associate" employees must contact the Security/Privacy Officer and verify that a business associate contract is in place.

"Business associate" is an entity that:

- Performs or assists in performing a company function or activity involving the use and disclosure of protected health information (including claims processing or administration, data analysis, underwriting, etc.); or
- Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

Disclosures of D-Identified Information

The DMCC may freely use and disclose de-identified information. De-identified information is health information that does not identify an individual. Respect is given to the fact that there is no reasonable basis to believe the information can be used to identify an individual. There are two ways a covered entity can determine when information is de-identified: either by professional statistical analysis, or by removing 18 specific identifiers listed below – relating to the participant, employee, relatives, or employer, and being certain there is no other available information that could be used alone or in combination to identify an individual.

1. Names
2. Geographic subdivision smaller than a state
3. All elements of dates (except year) related to an individual – including dates of admission, discharge, birth, death – and for persons >89 years old, the year of birth cannot be used
4. Telephone numbers
5. FAX numbers
6. Electronic mail addresses
7. Social security number
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Device identifiers and serial numbers
14. Web URLs
15. Internet protocol addresses
16. Biometric identifiers, including finger and voice prints
17. Full face photos and comparable images
18. Any unique identifying number, characteristic or code

A person with appropriate expertise must determine that the risk is very small regarding the information that could be used alone or in combination with other reasonably available information by an anticipated recipient to identify the individual. This person is required to document the methods and justification for this determination.

Disclosure to Family, Friends or Others – Participant Location

There are instances when a participant's friend or family member contacts the DMCC to ask about the location of a client or whether the client has been seen at the DMCC. Following is guidance provided to assist staff in providing appropriate responses for specific situations that commonly occur. In rare cases of emergency, and at the discretion of the Director of the DMCC, a minimum amount of information may be released in order to assist in resolving an emergency situation.

Guidance

Situation: Friends or family are concerned about the whereabouts of a person. They contact the DMCC and ask if a person is at the DMCC or has been seen as a client recently.

Response

For any inquiry regarding a current or past client, DMCC clinic staff should take the name of the caller, purpose for calling and state the caller will receive a return call from DMCC. DMCC staff should check if releases of information are on file. If they are on file, DMCC should make contact with the parent/client to inform them of the nature of the release of information. If parent/client agrees, DMCC will return the call and provide only the minimum information required.

If releases of information are not on file, DMCC must inform the caller that DMCC cannot confirm or deny the person is a client. If the friends and/or family are concerned about the person's wherabouts, DMCC can recommend they call other relatives of the person and/or contact the local police department to inquire about safety.

Situation: An individual comes to DMCC and tells the receptionist they have arrived to pick up a client.

Response

The DMCC serves children birth to 22 years old. Parents, guardians, or a responsible adult brining the child to treatment is expected to remain on the premises throughout the child's treatment service. In the event, the parent, guardian, or responsible adult leaves the premises, the child will contact the parent by phone. Any individual requesting information about a client will only be given information if a Release of Information is on file allowing the DMCC to share information with that specific individual.

Removing PHI from Company Premises

PHI is not allowed to leave the organization's premises at any time.

Introduction

In 1996, the United States Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was designed to accomplish a number of objectives, one of which is to protect the privacy of individually identifiable health information. Protection standards exist for protected health information (PHI) in all forms, including electronic formats (ePHI).

The standards set forth by HIPAA apply to "covered entities," including health care providers and the agencies they work within. The Desert/Mountain Children's Center (DMCC) is a covered entity and is thus required to comply with the regulations specified by HIPAA. This manual details the policies and procedures established for the DMCC to ensure HIPAA compliance.

HIPAA Privacy and Security Plan

The HIPAA Act of 1996 and its implementing regulations restrict DMCC's abilities to use and disclose protected health information (PHI).

Protected Health Information. Protected health information is information that is created or received by the DMCC and relates to the past, present, or future physical or mental health condition of a Patient/Client ("Participant"); the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

Some examples of PHI are:

- Participant's chart record number
- Participant's demographic information (i.e., address, telephone number)
- Information clinicians, psychologists, and other health care providers put in a participant's clinical record
- Images of the participant
- Conversations a provider has about a participant's care or treatment with other staff
- Information about a participant in a provider's computer system or a health insurer's computer system
- Billing information about a participant at a clinic
- Any health information that can lead to the identity of an individual or the contents of the information can be used to make a reasonable assumption as to the identity of the individual

It is DMCC's policy to comply fully with HIPAA's requirements. To that end, all staff members who have access to PHI must comply with HIPAA Policies and Procedures (See Appendix A). For purposes of this plan and DMCC's use and disclosure procedures, the workforce includes individuals who would be considered part of the workforce under HIPAA such as employees, volunteers, student interns, board members, and other persons whose work performance is under the direct control of DMCC, whether or not they are paid by DMCC. The term "employee" or "staff member" includes all these types of workers.

No third-party rights (including but not limited to rights of participants, beneficiaries, covered dependents, or business associates) are intended to be created by this Plan. DMCC reserves the right to amend or change this plan at any time without notice.

All staff members must comply with all applicable HIPAA privacy and information security policies. If after an investigation a staff member is found to have violated the organization's HIPAA privacy and information security policies, then the staff member will be subject to disciplinary action up to termination or legal ramifications if the infraction requires it.

E-PHI

The federal HIPAA's Security Regulation requires mental health and other small health care practices to meet administrative, physical, and technical standards to protect the confidentiality, integrity, and accessibility of their Protected Health Information (ePHI). The Regulation is in large part intended to prevent computer hacking, identity theft-related crime, and similar issues posed by the use of electronic information technology in health care practices and to create a general "culture of security" in those practices.

The federal Health Information Technology for Economic and Clinical Health (HITECH) Act was passed as part of the American Recovery and Reinvestment Act of 2009 (ARRA) and it broadens the privacy and security protections under HIPAA. Specifically, HITECH requires covered entities to notify affected individuals and the Secretary of Health and Human Services (HHS) in the event of a breach of their "unsecured PHI". Many state laws impose similar or overlapping obligations on businesses.

Another significant change brought about by HITECH is that a covered entity's "business associates" (and their subcontractors) are now directly subject to HIPAA's Security Regulation. HITECH also broadened, (and in some cases, narrowed) the definition of "business associate". Thus, a practice's security program should require the practice to keep a closer eye on its business associate relationships, as discussed in greater detail below.

The HIPAA Final Rule released on January 17, 2013, amended HIPAA's privacy and security rules to implement the foregoing HITECH requirements. The definition of what constitutes a "breach" of PHI was also broadened by the Final Rule, which now requires a practice to "presume" that any non-permitted acquisition, access, use or disclosure of PHI is a breach under HIPAA requiring notification to affected individuals and HHS in accordance with HIPAA regulations. In determining whether a covered entity can overcome the presumption of a breach, the Final Rule requires covered entities to undergo a "risk assessment" based on several factors to determine whether there was a low probability that the PHI was compromised by the non-permitted acquisition, access, use or disclosure. The Final Rule also increased civil money penalties payable to HHS for uncorrected violations and willful neglect of HIPAA requirements.

HITECH and the Final Rule made few changes to the technical standards of the Security Regulation and a full analysis of HITECH and the Final Rule is therefore beyond the scope of this Manual. Nevertheless, in implementing and maintaining a security program, practices should be aware of the changes summarized above. Now more than ever, HHS is bringing enforcement

actions against providers and business associates for breaches of unsecured PHI. Given this heightened enforcement environment and the broadening of the privacy and security rules under HITECH and the Final Rule, practices are well advised to increase their focus and involvement in maintaining a strong security program consistent with the Security Regulation.

The Security Regulation applies only to electronic data used, transmitted, or maintained by the practice (unlike the HIPAA Privacy Regulation which covers health information on paper or in any other form). However, practitioners should remember that the Regulation's definition of electronic Protected Health Information includes demographic, health and financial information which might include name, address, social security number, credit card numbers, insurance plan numbers, or other identifiers.

The HIPAA Security Regulation is not highly specific. The Regulation essentially requires health care practices to take ***reasonable and appropriate*** measures to protect against ***reasonably anticipatable*** threats to the practice's ePHI. The Regulation sets a series of 18 standards for the protection of electronic health information and a total of 36 implementation specifications to help health care providers address what needs to be done to meet those standards. The HIPAA Security Regulation is outlined in the following pages with standards and implementation specifications.

Compliance with ***all*** standards is ***required.*** In most cases, compliance with the implementation specifications under a standard will constitute compliance with the standard. Implementation specifications are divided into ***required*** specifications that must be implemented exactly as indicated and ***addressable*** specifications which can be adapted in a manner reasonable and appropriate to the practice so as to address reasonably anticipatable risks to ePHI. However, the Centers for Medicare and Medicaid Services (CMS), the enforcement agency for the Regulation, emphasizes that "addressable" does not mean "optional". Should a practice not implement an addressable measure exactly as indicated, the practice must document alternative measures and the reason they were taken. **Compliance with all the standards and specifications must be documented.**

Section I: Descriptions and Definitions

Administrative Safeguards: Administrative safeguards refer to these policies and procedures used by the Desert/Mountain Children's Center (DMCC) to comply with HIPAA standards.

I. Security/Privacy Officer

The Director of the DMCC is the designated Security/Privacy Officer and is responsible for knowing HIPAA regulations, training the DMCC staff which includes, clinical staff (student interns, Intervention Specialists, Behavioral Health Counselor I, Behavioral Health Counselor II, Clinical Counselors and Behavioral Health Counselor Supervisors), administrative staff, and support staff (business, clerical, and student workers) in HIPAA compliance, and assuring that HIPAA related policies and procedures are instituted and followed. The Security/Privacy Officer will:

- Update HIPAA policies and procedures
- Oversee the implementation of the policies and procedures contained in this Manual
- Ensure that all clinic personnel are trained regarding HIPAA and the policies and procedures of the clinic on an annual basis
- Review activity that takes place in the clinic to detect security risks
- Investigate and respond to security incidents and take appropriate action in the event of a breach in security and eliminate or mitigate any damaging effects.

II. Training Program

All clinic personnel are required to participate in a formal HIPAA training program. The training program was instituted at DMCC in the fall of 2007, and all existing personnel were required to complete the training. All new employees receive the training within 30 days of their employment with DMCC.

The training involves attending the HIPAA Training for covered Entities and signing the Employee Agreement for both HIPAA and the Omnibus rules. Additionally, this Manual is available to all DMCC personnel through the web-based Live Binder. It is also available as a hard copy in the clinic office.

III. Documentation of Training

Training of DMCC personnel will be recorded in an electronic HIPAA Training Log.

IV. HIPAA Notification

All clients who receive DMCC services are given a *HIPAA Notice of Privacy Practices (NOPP)* document before their first session. They sign a document indicating they

have received the Notification. Additionally, a HIPAA Notification document is posted in the waiting room of the clinic.

V. Release of Information

Client PHI is only released to another party when the release is requested, in writing, by the client or the client's legal guardian. The *Release of Health Information* form is completed when a request is made.

The exceptions to the release of PHI without a signed release of information occurs only in accordance with strict policies (i.e., harm to self and/or others).

Ensuring Disclosures are the Minimum Necessary

When a request is received to disclose PHI, the request is reviewed by a DMCC program manager. The document will clearly state what is to be released and the minimum will be disclosed. The principle guiding the release of PHI is to limit disclosure of information not reasonably necessary to accomplish the purpose for which the request is made.

Accounting for Disclosures

The DMCC support staff will identify in its database, per child any disclosures to external agencies whenever a release of information is requested by a client.

Request for File Review and Copy

Clients and/or legal guardians of clients, who have records with the DMCC may request to inspect and obtain a copy of their PHI in the "designated record set," defined as the medical and billing records maintained by the clinic and used to make decisions about the client. The request must be made in writing and will be fulfilled within 30 days of receipt. HIPAA generally gives providers discretion to disclose the individual's own protected health information (including psychotherapy notes) directly to the individual or the individual's personal representative.

Deleted: HIPAA does not allow clients to have access to their therapist's psychotherapy notes.

Requests to Amend a Record

Clients and/or legal guardians of clients, have the right to amend their record if they believe the record is incomplete or not accurate. The amendment will become part of their ongoing file. Requests for record amendments must be made in writing. Clients may not expunge any prior information or part of the Record.

VI. Security Assessment and Reporting

The DMCC Director will engage in a yearly assessment of the clinic's adherence to the policies detailed in this manual. As part of the annual facility assessment, teams

consisting of administrative staff and clinicians will be asked to assess any potential security problems and to recommend additional security measures.

Reporting of Security Violations

DMCC personnel are required to report any violations of HIPAA standards to the Security/Privacy Officer.

Responding to Violations and Preventing Further Violations

When security incidents or deficiencies are reported or discovered, the Security/Privacy Officer will investigate the situation and complete the *HITECH Act Breach Notification Risk Assessment Tool* (see Appendix B). The breach tool will contain any corrective measures as needed. Corrective measure may include personnel re-education, policy revision, building modification, and/or equipment alterations.

VII. Policies and Procedures to Access Protected Health Information

Access to PHI is limited to DMCC personnel and business associates and further restricted to the information needed by personnel to complete a job function and/or clinical training.

VIII. Business Associates

"Business associates" are defined by HIPAA as third parties who provide services to DMCC and involve the use or disclosure of protected health information. The DMCC currently has business associate agreements. In the event DMCC enters into an additional arrangement with a business associate, a Business Associate Agreement will be adopted and utilized.

Deleted: may have access to electronic patient health information…

IX. Research Activities

Client information may not be used for research or marketing purposes unless the client has agreed to allow his/her PHI to be used in this manner. All research projects must also be approved by the CAHELP Institutional Review Board.

X. Clinic Visitors

Occasionally visitors tour the DMCC facility as they are learning to create their own programs. All visitors must be escorted by DMCC personnel who ensure PHI is not disclosed or visible.

Section II: Physical Safeguards

Physical safeguards refer to the processes in place in which DMCC controls physical access to protected information.

Building Access

Access to the DMCC, except for the lobby is limited to DMCC personnel who are given a key(s) to the building and are required to wear their identification badge to enter the treatment rooms and/or administrative staff area. Keys are dispersed by the Operations Officer of the CAHELP who maintains a record of key distribution and a signed document from the employee of receipt of the key(s). Upon termination, DMCC administrative staff will collect the key(s) from the employee and return it to the Operations Officer of CAHELP.

Mailboxes

Written communication pertaining to DMCC and clinical work is distributed via personnel mailboxes housed within DMCC offices. These mailboxes are kept behind locked doors.

Session Recordings

Recordings are made of certain sessions with the permission of the client and/or guardian of the client depending on the type of treatment they are receiving (i.e., Parent-Child Interaction Therapy – PCIT, Theraplay, etc.). Recordings are digitized and maintained in a locked file. The recordings are not allowed to leave the premises. Recordings are only to be utilized for the purpose as clearly identified on the permission to record document.

Documentation

Session notes are recorded in Athena Software (Penelope) and Netsmart myEvolv, both secure electronic medical records systems. Report copies may also be kept in the client files.

Document Retention

Electronic medical records in Penelope and myEvolv are maintained indefinitely in this secure medium. Any client paper files are maintained behind a locked chart room in a file cabinet. The room holding client files is locked after hours as well. Any files maintained are housed in locked cabinets behind two sets of locked doors when DMCC is not open for business. Paper files of terminated clients are scanned in Penelope and/or myEvolv and stored at a secured facility.

Deleted: on

Deleted: in

Deleted: that is open during business hours and locked thereafter

Section III: Technical Safeguards

Technical safeguards refer to the procedures in place to control access and/or interception to computer systems and to protect all communications containing PHI transmitted electronically.

Electronic Medical Records System (Penelope)

DMCC uses both Penelope and myEvolv software, electronic medical records systems designed specifically for counseling centers and psychology training clinics. Penelope and myEvolv may only be accessed by DMCC personnel, each of which has a unique username and password. Access is restricted by safety measures in the system that restrict users from being able to view records of clients who are not their own. Once files are saved, they cannot be changed or erased without a clear electronic tracking of any activity and clear identification of who accessed records. Full access to Penelope is granted only to limited staff including the administrative staff, support staff and technology personnel to maintain the program.

Computer Workstations

All computer access is secure from clients, parents and/or visitors to the DMCC. The reception area computer (which is behind glass and locked doors) is turned off each day after business hours. All DMCC personnel log off of Penelope and myEvolv before leaving them unattended. Documents are kept, completed and maintained in Penelope through the network server and/or client hard files.

Mobile Devices

All organizationally purchased mobile devices used by the DMCC staff have a Mobile Device Management (MDM) application installed on them that allows for remote management and wiping of the device if it is lost or stolen.

Computer Flash Drive

The use of flash drives or portable electronic media to store ePHI data is prohibited.

Cloud Storage

The use of cloud storage to store ePHI is allowed when it is a DMCC approved HIPAA compliant cloud storage.

Faxing

The fax machine at DMCC is housed in a locked area of the clinic. The fax machine is checked throughout the day to ensure faxed documents are not left unattended.

If faxing, only the PHI needed is sent, and a cover letter with a confidentiality statement accompanies the information to help prevent casual reading. Additionally, frequently used fax numbers are programmed into the machine to ensure accuracy in dialing. New fax numbers are verified before PHI is transmitted. The machine does not have the capacity to save copies of faxed information.

Email

DMCC uses an encrypted email solution when emailing client PHI information to entities outside of the network. The encryption process is accomplished with software on our email gateway server. All DMCC personnel have been trained to use "Encrypt" on the subject line to ensure proper encryption. Client level information is attached with a privacy statement in the body of the email. Privacy notices on all emails is appended as part of the sending process and is enforced from the system.

Telephone

Phone calls are made to clients and/or guardians from the office area for routine appointment reminders and appointment clarification. The office area is behind locked doors and a glass partition. All information occurs away from all clients, guardians, and visitors.

Electronic Health Records Policy and Procedures

Electronic Health Records (EHR) complies with HIPAA, and all state and federal laws related to protection of personal health information. EHRs can be encrypted (making the document(s) unreadable to anyone other than an authorized user) and security access parameters set to only authorized individuals can view them. EHRs also offer the added security of an electronic tracking system that provides an accounting of the history of when records have been accessed and by whom.

General Information

System users who send, receive, store and access ePHI must comply with DMCC's Electronic Health Records Policy and Procedures.

I. Policy

DMCC provides physical attributes required to protect information systems and related infrastructure from unauthorized access in accordance with HIPAA Security Rules to protect the availability, confidentiality, and integrity of client and departmental confidential information.

DMCC personnel are responsible for maintaining the physical security of DMCC's computer resources under their control. They are also responsible for protecting the integrity and privacy of the data maintained on the computer by using appropriate lockdown devices, password-controlled access, data encryption, virus protection software, and routine backup procedures.

DMCC is under the umbrella of the California Association of Health and Education Linked Professions (CAHELP), which is a department of San Bernardino County Superintendent of Schools (SBCSS). SBCSS, CAHELP, and DMCC reserve the right to inspect all data and to monitor the use of all its computer systems.

All computer users have no right to privacy regarding information on organizationally supplied computers. Personnel are not allowed to place any client information (ePHI) on personally owned technology devices. The organization reserves the right to remotely access, monitor, control, and configure organizationally supplied computers and any software residing on said device. Non-compliance with this policy is subject to management review and action up to and including termination of employment, vendor contract, and/or legal action.

- All computers are equipped with updated software for detecting the presence of malicious software (i.e., computer viruses). All computing devices have current versions of anti-virus software enabled. Operating systems have all critical updates installed.
- All computers are positioned or located in a manner that minimizes the exposure of displayed patient and/or sensitive business information.

- DMCC personnel accessing the DMCC network or information from remote locations are trained to utilize appropriate security safeguards.
- DMCC through the CAHELP and with SBCSS's direction and approval shall have the ability to recommend and implement hardware, operating systems, and connectivity solutions to be supported. System support of any proposed solutions will need to be included in the purchasing decision.
- DMCC personnel may not independently install hardware or software solutions that allow remote access to organizationally purchased devices.
- DMCC personnel must comply with DMCC's policies and state and federal laws and regulations regarding the proper acquisition, use and copying of copyrighted software and commercial software licenses.

II. PURPOSE

The DMCC is committed and required to provide security to protect its computerized clinical and business information systems. DMCC computer system hardware and software as well as the information and data carried by the system are the property of the CAHELP/SBCSS. Any misuse of DMCC computers may result in denial of access to the system network and systems, DMCC information, and data. The intent of this policy is to:

- Ensure each system containing ePHI has the necessary access controls to restrict unauthorized users and programs from accessing patient health or sensitive business information.
- Ensure software on each computer on the network is internally compatible and will not lead to degradation of the system.
- Ensure users are oriented and trained on computer use and maintenance of information integrity, privacy, and resource security.
- Establish security requirements for the appropriate use of mobile computing resources including laptops and mobile computing devices that access DMCC information or interface with the DMCC network.

III. SCOPE

This policy applies to all DMCC personnel, vendors, contractors, and business associates who have access to DMCC client information, either clinical and/or business related, stored on DMCC computers or have access to its computer resources or network. The scope of this policy includes the usage of all and any device that directly or remotely accesses the DMCC network.

IV. DEFINITION

Portable-Computer Device: A portable-computing device is a computer that is easily transported by hand and could store DMCC client and/or business information. "Portable computing device" generally refers to laptop computers, smart clipboards, and mobile computing devices but can include other emerging technologies that allow

storage of and access to information and are capable of connection (physical or wireless) to the computer network, including connection to any server or computer on the computer network.

V. PROCEDURES

General

1. Users are required to log-off of applications containing client health and/or sensitive business information before leaving their computers.
2. Users must save work that contains ePHI in accordance with approved data storage policies.
3. All laptops and any other portable computer equipment must be secured (protected) when not in use.
4. Storing ePHI information on ANY Device that is not encrypted is prohibited.
5. Storing of PHI information on a personal device is prohibited.
6. Employees are responsible for breaches of security related to devices in their possession.
7. All computers require a complex-level password protection with the computer system. In order to access any client health and/or business information, a second level of authentication protection is required to access information.
8. There are no circumstances when security provisions are allowed to be disabled.
9. DMCC personnel are required to have appropriate clearance prior to access to computers and the Penelope network.
10. Upon termination or change of job position, users will have network access removed or modified as deemed appropriate by administration.
11. All computer devices shall be tagged and tracked by administration in accordance with SBCSS's asset management policies and procedures.

Desktop Computers

DMCC has established standard configurations for desktop technologies deployed throughout the organization. All computers, computer peripherals, and software as well as printers, faxes, and other miscellaneous hardware purchased with DMCC funds or attached to any component of the DMCC network must meet these standards.

Installation of any personal software, whether purchased or downloaded, by employees is prohibited. Software required for end user productivity must be approved by the Director and installed by CAHELP/SBCSS helpdesk staff.

Desktop computers are located in areas that are physically separate and face away from the public.

Computer access and password training provided by the DMCC administrative staff must be completed prior to granting access privileges to ensure adequate training has occurred.

Desktop computers are equipped with security hardware and/or software. Computers **must** comply with all software updates for detecting the presence of malicious software. All devices will have current versions of anti-virus software enabled. Operating systems will have all critical updates installed.

Mobile devices that store ePHI will be secured using compliant measures.

Organizationally Supplied Portable/Mobile Computer Devices

The loss or theft of any portable computer device storing DMCC client and/or sensitive business information shall be immediately reported to the employee's supervisor. The supervisor will contact the DMCC Security/Privacy Officer.
Startup authentication and authorization passwords (username and password) are required on all computers. Storing or caching username and passwords on any device is prohibited.

Organizationally supplied portable computer devices storing data belonging to the DMCC may not be shared with others, especially non-employees, who are not authorized to access the information unless the information is stored as encrypted password protected files.

DMCC reserves the right to identify sensitive information and initiate methods to secure this information.

Personally Supplied Portable/Mobile Computer Devices

The use of personally supplied devices by DMCC/CAHELP personnel in support of the organization's mission or work is strictly prohibited.

Remote Access

Access to DMCC's internal remote location will be done through appropriate Virtual Private Network (VPN) services and must be approved by the Security/Privacy Officer.

Access to DMCC's internal network from outside of its defined network perimeter will be controlled by VPN access controls that may only be established by technical staff.

Users are not authorized to install hardware or software solutions that would allow remote access to their organizationally supplied computing devices.

VPN connections will be strictly controlled, implemented, and maintained by SBCSS technical staff.

VI. Staff Use of System and Privileges

Monitoring of computer use

Personnel utilizing DMCC systems should have no expectation of privacy. The DMCC will log, review, or monitor any data stored or transmitted on its information systems to manage those assets to ensure compliance with the agency's policies.

Removal of staff privileges

The DMCC may remove or deactivate any employee's network privileges, including but not limited to, user access accounts and access to secured areas, when necessary to preserve the integrity, confidentiality and availability of its facilities, user services, and data.

System Security

Each computing device used to access, transmit, receive, or store ePHI must comply with DMCC policies. If any policy requirement is not supported by the workstation operating system or system architecture, one of the following steps must be taken:

- The system must be upgraded to support all of the following security measures
- An alternative security measure must be implemented and documented
- The computer must not be used to send, receive, or store ePHI

VII. Data Maintenance and Emergency Procedures

Server

Since 2007, private health information at the DMCC that is ePHI is maintained by an Electronic Medical Records System (Penelope). Penelope is a cloud-based system that provides for redundancy and disaster recovery solutions. The data sheet for Penelope can be found at:

http://www.athenasoftware.net/resources/Penelope_PRIVACY_AND_SECURITY_Whitepaper_2014.pdf

Since March 2020, private health information at the DMCC that is ePHI is maintained by an Electronic Medical Records System (Netsmart myEvolv). myEvolv is a cloud-based system that provides for redundancy and disaster recovery solutions. The data sheet for myEvolv can be found in Appendix D.

Technical staff are responsible to ensure all servers used to access, transmit, receive or store ePHI are appropriately secured with this policy.

1. **Server Location**

DMCC in-house (non-cloud) servers currently reside at a secure facility. All data not stored in the cloud solution is stored on these systems.

- Servers are located in a physically secure environment
- The system administrator account is password protected
- A user identification and password authentication mechanism is implemented to control user access to the system
- A security patch and update procedure is established and implemented to ensure all relevant security patches and updates are promptly applied based on the severity of the vulnerability corrected
- Servers are located on a secure network with firewall protection
- All unused or unnecessary services are disabled

2. **Computer Security**

Technical staff are responsible to ensure each computer system used to access, transmit, receive, or store ePHI is appropriately secured in accordance with this policy. A user identification and password authentication mechanism is implemented to control user access to the system.

- All users must be issued a unique username for accessing PII
- Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, within 24 hours
- Passwords are not to be shared
- Passwords must be at least eight characters and complex
- Passwords must not be cached
- Passwords must be changed every 180 days.
- Passwords must be changed if revealed or compromised.
- Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:
  - Upper case letters (A-Z)
  - Lower case letters (a-z)
  - Arabic numerals (0-9)
  - Non-alphanumeric characters (punctuation symbols)
- A security patch and update procedure are established and implemented to ensure all relevant security patches and updates are promptly applied based on the severity of the vulnerability corrected: All computers and devices that process and/or store PII must have critical security patches applied including those patches that require a system reboot. The patch management process determines installation timeframe based on risk assessment and vendor recommendations. All applicable patches deemed as high risk must be installed as soon as practical. Applications and systems unable to be patched within this time frame, due to significant operational reasons, must have compensatory controls implemented to minimize risk.

- A malware detection system is implemented including a procedure to ensure the detection software is maintained and up to date
- All unused or unnecessary services are disabled
- An automatic logoff or inactivity timeout mechanism is implemented
- The computer screen or display must be situated in a manner that prohibits unauthorized viewing. The use of a screen guard or privacy screen may be used
- Laptop devices will have hardware level disk encryption
- **Data Destruction:** When an electronic storage device that contains PII is sent for destruction, it is erased using the US Department of Defense clearing and sanitizing standard DoD 5220.22-M or equivalent
- **System Timeout:** The system providing access to PII must provide an automatic timeout, requiring re-authentication of the user session after no more than 30 minutes of activity
- **System Logging:** The system maintains an automated audit trail that can identify the user or system process, initiates a request for PII, or alters PII. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If PII is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three years after occurrence
- **Access Controls:** The system providing access to PII must use role-based access controls for all user authentications, enforcing the principle of least privilege
- **Transmission Encryption:** All data transmission of PII outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm that is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PII can be encrypted. This requirement pertains to any type of PII in motion such as website access, file transfer, and email
- **Intrusion Detection:** All systems involved in accessing, holding, transporting, and protecting PII, which are accessible through the Internet, must be protected by a comprehensive intrusion detection and prevention solution

3. Logoff Procedures

To ensure security to all servers and computers accessing, transmitting, receiving, and/or ePHI, the following procedures must be followed:

Automatic Logoff Procedures

- Servers, computers, and other electronic devices containing ePHI must employ inactivity timers or automatic logoff mechanisms
- Servers, computers, and other electronic devices containing ePHI must terminate a user session after a maximum of, but not limited to, 30 minutes of inactivity

- When a system requires the use of an inactivity timer or automatic logoff mechanism but does not support an inactivity timer or automatic logoff mechanism, one of the following procedures must be implemented:
  - The system must be upgraded to support the minimum HIPAA Security
  - The system must be moved into a secure environment
  - ePHI must be removed and relocated to a system supporting the minimum requirements

Logging off the System

When a server, computer, or other electronic device is unattended users must lock or activate the systems Automatic Logoff Mechanism (e.g., CTRL, ALT, DELETE and Lock computer), or logout of all applications and database systems containing confidential information.

Network and Privacy Settings

Schedule for Backups

Backups are scheduled nightly and are encrypted to offsite, encrypted storage. Backups are maintained for a two-week period.

Recovery Plan for Data

On premises servers are backed up regularly using VM-level backups. Servers and data can restore all data necessary to the version from the night before. There is also a database-level backup of Penelope data that is performed daily. Details for back and recovery for clouds servers can be found in (See Appendix C).

Security Protocols for Access to Data

Password resets are in effect every 180 days for all users.

Encryption security level

- Computers and server storage is encrypted where necessary
- Intra site communication is direct and secure so no special encryption is necessary.

Firewalls

The DMCC has firewalls installed at internet connection points at the primary datacenter and disaster recovery datacenter. Firewalls are maintained and patched by a firewall vendor. Inbound access is analyzed using an IPS/IDS, Intrusion Prevention Systems and Intrusion Detection system, device which scans all inbound and outbound traffic for malicious attacks. Both datacenters are secured,

and access is controlled with the use of a key card access system. Only authorized personnel are permitted to access our datacenters. The primary data center power is protected using a natural gas generator and halon fire suppression system.

Remote Access

Access from outside of DMCC is available only through approved VPN secured connections with encrypted and physical security checks.

VIII. Electronically Signed Records

For the purpose of this policy an electronically signed record is a financial, program, or medical record that (1) is required to be signed under California or Federal law, California or Federal regulation, or organizational policy or procedure, and (2) may be requested during an audit.

Standards for Electronic Signatures in Electronically Signed Records

Electronic signatures in electronically signed records will be viewed as equivalent to a manual signature affixed by hand for financial, program, and medical records for audit purposes as defined under the California Code of Regulations, Title 9.

DMCC's policy for electronic signature meets the following requirements:

1. DMCC's computer system (Penelope and myEvolv) utilizes electronic signatures that comply with the following Certification Commission for Healthcare Information Technology (CCHIT) certification criteria or equivalent: *Security: Access Control, Security: Audit, and Security: Authentication.*
2. The electronic signature mechanism is (a) unique to the signer, (b) under the signer's sole control, (c) capable of being verified, and (d) linked to the data so that, if the data are changed, the signature is invalidated. Additionally, DMCC will maintain physical signatures for all clinical staff on file as backup.
3. DMCC will maintain an Electronic Signature Agreement for the terms of use of an electronic signature signed by both the individual requesting electronic signature authorization and the county mental health director or his/her designee.
4. DMCC will request and maintain an Electronic Signature Certification from entities where contracts are held through the Department of Behavioral Health where such is required.
5. The signed *Electronic Signature Certification* and signed *Electronic Signature Agreements* forms will be available to the auditor at the time of an audit.

Information Security Considerations

DMCC's standard encryption of data is also employed in the electronically signed record.

Obtaining Consumer Signatures

In many situations, the mental health consumer, or his/her representative, must acknowledge his/her willingness to participate in and accept the treatment plan. In paper-based systems, the consumer, or his/her representative, physically signs a document to that effect. As an alternative to paper, it is DMCC's policy the following approaches will be utilized: (1) scanning paper consent documents, treatment plans, or other medical record documents containing consumer signatures or (2) capturing signature images from a signature pad.

DMCC will maintain all information and will be in full compliance with all applicable HIPAA electronic signature standards. Upon future publication of HIPAA electronic signature regulations, the DMCC will be in full compliance within the timelines and all requirements established by state and federal government.

Requirements for Electronically Signed Records

The DMCC will utilize electronic records and electronically signed records to replace all paper-based records for purposes of an audit. When an audit is conducted, the DMCC shall make available the following upon arrival of the auditor at the audit site:

- Physical access to electronic health record systems
- Adequate computer access to the electronic health records needed for the audit review
- System or network access to electronic records such as user IDs and passwords
- Access to printers and capability to print necessary documents
- Technical assistance as requested
- Scanned documents, if needed, which are readable and complete

PHI – Personal Health Information

PHI and PII Use and Disclosure

PHI Definition and Data Elements

Below is an excerpt from the U.S. Department of Health & Human Services defining PHI and PHI data elements:

Protected Health Information: The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information *protected health information* (PHI).

Individually identifiable health information is information, including demographic data, that relates to:

- The individual's past, present or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual,
- The individual's identity or for which there is a reasonable basis to believe it can be used to identify the individual

Individually identifiable health information includes many common identifiers (i.e., name, address, birth date, Social Security Number) and generally encompasses all PII (see below). All PHI is protected by both HIPAA and ethical standards.

PII Definition and Data Elements

Per the Executive Office of the President, Office of Management and Budget (OMB) and the U.S. Department of Commerce, Office of the Chief Information Officer, The term *personally identifiable information* refers to information that can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc." Any information that is personal is protected by privacy laws.

California Senate Bill SB 1386: *personal information* means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted:

1. Social Security Number
2. Driver's license number or California Identification Care number
3. Account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial account

Use and Disclosure Defined

The DMCC will use and disclose PHI only as permitted under HIPAA. The terms "use" and "disclosure" are defined as follows:

- *Use* – The sharing, employment, application, utilization, examination, or analysis of individually identifiable health information by any person working for or within the company, or by a business associate of the company
- *Disclosure* – for information that is protected health information, disclosure means any release, transfer, provision of access to, or divulging in any other manner of individually identifiable health information to persons not employed by or working within DMCC with a business "need to know" PHI

Access to PHI is Limited to Certain Employees

All personnel who perform Participant functions directly on behalf of the DMCC or on behalf of group health plans will have access to PHI as determined by their supervisor, job description, and as granted by IT. These employees with access may use and disclose PHI as required under HIPAA but the PHI disclosed is limited to the minimum amount necessary to perform the job function. Employees with access may not disclose PHI unless an approved compliant authorization is in place or the disclosure otherwise is in compliance with this Plan and the use and disclosure procedures of HIPAA.

Personnel may not access either through the information systems or the participant's medical record the medical and/or demographic information for themselves, family members, friends, staff members, or other individuals for personal or other non-work-related purposes, even if written or oral participant authorization has been given. If the employee is a participant in DMCC's plans, the employee must go through their provider in order to request their own PHI.

In the very rare circumstance when an employee's job requires him/her to access and/or copy the medical information of a family member, a staff member, or other personally known individual, then he/she will immediately report the situation to his/her supervisor who will assign a different staff member to complete the task involving the specific participant.

Personal access to your own PHI is based on the same procedures available to other participants not based on job-related access to our information systems. For example, if you are waiting for a lab result or want to view a clinic note or operative report, you must either contact your provider for the information or make a written request to the Security/Privacy Officer. Employees may not access their own information; they must go through all the appropriate channels as participants are required to do.

Disclosure of PHI Pursuant to an Authorization

PHI may be disclosed for any purpose if an authorization satisfying HIPAA requirements for a valid authorization is provided by the participant. All uses and disclosures made pursuant to a signed authorization must be consistent with the terms and conditions of the authorization.

Permissive Disclosures of PHI: For Legal and Public Policy Purposes

PHI may be disclosed in the following situations without a participant's authorization, when specific requirements are satisfied. DMCC's use and disclosure procedures describe specific requirements that must be met before these types of disclosures may be made. Permitted are disclosures:

- About victims-of-abuse, neglect or domestic violence;
- For judicial and administrative proceedings – with appropriate subpoenas;
- For law enforcement purposes;
- For certain limited research purposes;
- To avert a serious threat to health or safety;
- For specialized government functions; and
- That relate to workers' compensation programs.

Complying with the "Minimum-Necessary" Standard

HIPAA requires when PHI is used or disclosed, the amount disclosed generally must be limited to the "minimum-necessary" to accomplish the purpose of the use or disclosure. The "minimum-necessary" standard does not apply to any of the following:

- Uses or disclosures made to the individual;
- Uses or disclosures made pursuant to a valid authorization;
- Disclosures made to the Department of Labor;
- Uses or disclosures required by law; and
- Uses or disclosures required to comply with HIPAA.

Minimum-Necessary When Disclosing PHI

For making disclosures of PHI to any business associate or providers, or internal/external auditing purposes, only the minimum-necessary amount of information will be disclosed. All other disclosures must be reviewed on an individual basis with the Security/Privacy Officer to ensure the amount of information disclosed is the minimum necessary to accomplish the purpose of the disclosure.

Minimum-Necessary When Requesting PHI

For making request for disclosure of PHI from business associates, providers, or participants for the purposes of claims payment/adjudication or internal/external auditing purposes, only the minimum necessary amount of information will be requested.

All other requests must be reviewed on an individual basis with the Security/Privacy Officer to ensure the amount of information requested is the minimum necessary to accomplish the purpose of the disclosure.

Protected Health Information (PHI): Patient information, including demographic information, that:

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present, or future physical or mental health condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient; and
- Identifies the patient or can be used to identify a patient.

Lobby Interactions

DMCC personnel are not to reveal PHI in the lobby with clients. DMCC personnel will ask clients and/or parents to step into a confidential, private office to conduct conversations related to PHI.

Consequences of Violations

Personnel violations of DMCC systems as described above will be subject to disciplinary action that may include termination of employment.

Disclosure of PHI to Business Associates

Based on the approval of the Security/Privacy Officer and in compliance with HIPAA, employees may disclose PHI to the company's business associates and allow the DMCC's business associates to create or receive PHI on its behalf. However, prior to doing so, the DMCC must obtain assurances from the business associate agreeing to appropriately safeguard the information. Before sharing PHI with outside consultants or contractors who meet the definition of "business associate" employees must contact the Security/Privacy Officer and verify that a business associate contract is in place.

"Business associate" is an entity that:

- Performs or assists in performing a company function or activity involving the use and disclosure of protected health information (including claims processing or administration, data analysis, underwriting, etc.); or
- Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

Disclosures of D-Identified Information

The DMCC may freely use and disclose de-identified information. De-identified information is health information that does not identify an individual. Respect is given to the fact that there is no reasonable basis to believe the information can be used to identify an individual. There are two ways a covered entity can determine when information is de-identified: either by professional statistical analysis, or by removing 18 specific identifiers listed below – relating to the participant, employee, relatives, or employer, and being certain there is no other available information that could be used alone or in combination to identify an individual.

1. Names
2. Geographic subdivision smaller than a state
3. All elements of dates (except year) related to an individual – including dates of admission, discharge, birth, death – and for persons >89 years old, the year of birth cannot be used
4. Telephone numbers
5. FAX numbers
6. Electronic mail addresses
7. Social security number
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers including license plates
13. Device identifiers and serial numbers
14. Web URLs
15. Internet protocol addresses
16. Biometric identifiers, including finger and voice prints
17. Full face photos and comparable images
18. Any unique identifying number, characteristic or code

A person with appropriate expertise must determine that the risk is very small regarding the information that could be used alone or in combination with other reasonably available information by an anticipated recipient to identify the individual. This person is required to document the methods and justification for this determination.

Disclosure to Family, Friends or Others – Participant Location

There are instances when a participant's friend or family member contacts the DMCC to ask about the location of a client or whether the client has been seen at the DMCC. Following is guidance provided to assist staff in providing appropriate responses for specific situations that commonly occur. In rare cases of emergency, and at the discretion of the Director of the DMCC, a minimum amount of information may be released in order to assist in resolving an emergency situation.

Guidance

Situation: Friends or family are concerned about the whereabouts of a person. They contact the DMCC and ask if a person is at the DMCC or has been seen as a client recently.

Response

For any inquiry regarding a current or past client, DMCC clinic staff should take the name of the caller, purpose for calling and state the caller will receive a return call from DMCC. DMCC staff should check if releases of information are on file. If they are on file, DMCC should make contact with the parent/client to inform them of the nature of the release of information. If parent/client agrees, DMCC will return the call and provide only the minimum information required.

If releases of information are not on file, DMCC must inform the caller that DMCC cannot confirm or deny the person is a client. If the friends and/or family are concerned about the person's whereabouts, DMCC can recommend they call other relatives of the person and/or contact the local police department to inquire about safety.

Situation: An individual comes to DMCC and tells the receptionist they have arrived to pick up a client.

Response

The DMCC serves children birth to 22 years old. Parents, guardians, or a responsible adult brining the child to treatment is expected to remain on the premises throughout the child's treatment service. In the event, the parent, guardian, or responsible adult leaves the premises, the child will contact the parent by phone. Any individual requesting information about a client will only be given information if a Release of Information is on file allowing the DMCC to share information with that specific individual.

Removing PHI from Company Premises

PHI is not allowed to leave the organization's premises at any time.

California Association of Health and Education Linked Professions
Joint Powers Authority (CAHELP JPA)
DESERT/MOUNTAIN CHARTER SELPA EXECUTIVE COUNCIL MEETING
April 15, 2021 – 10:00 a.m. Virtual Via Video Conference
Desert Mountain Educational Service Center, 17800 Highway 18, Apple Valley CA 92307

MINUTES

COUNCIL MEMBERS PRESENT:
Allegiance STEAM Academy – Sebastian Cognetta, Aveson Global Academy – Kelly Jung, Aveson School of Leaders – Eva Neuer, Ballington Academy – Doreen Mulz, Desert Trails Preparatory Academy (DTPA) & La Verne Elementary Preparatory Academy (LEPA) – Debbie Tarver, Julia Lee Performing Arts Academy – Tanya Taylor, Odyssey Charter School – Lauren O'Neill, Pasadena Rosebud Academy – Shawn Brumfield, Pathways to College – Craig Merrill, Taylion High Desert Academy – Brenda Congo, and Virtual Prep Academy – Michelle Romaine.

CAHELP STAFF PRESENT:
Jamie Adkins, Heidi Chavez, Marina Gallegos, Jenae Holtz, Linda Llamas, Kami Murphy, Daria Raines, Adrienne Shepherd-Myles, and Jennifer Sutton.

1.0 CALL TO ORDER

The regular meeting of the Desert/Mountain Charter SELPA Executive Council Meeting was called to order by Chairperson Jenae Holtz, at 10:02 a.m., at the Desert/Mountain Educational Service Center, Apple Valley, California.

2.0 PUBLIC PARTICIPATION

None.

3.0 ROLL CALL

4.0 ADOPTION OF THE AGENDA

4.1 **BE IT RESOLVED** that a motion was made by Debbie Tarver, seconded by Shawn Brumfield, the April 15, 2021 Desert/Mountain Charter SELPA Executive Council Meeting Agenda as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

5.0 PUBLIC HEARINGS

5.1 Desert/Mountain Charter SELPA Annual Service Plan **(ACTION)**

California Education Code requires that an Annual Service Plan be approved by the CAHELP JPA Governance Council as part of the Local Plan. The 2021-22 Annual Service Plan describes all special education services currently provided in the Desert/Mountain Charter SELPA broken down by type, location, and level of severity.

5.1.1 **BE IT RESOLVED** that a motion was made by Tanya Taylor, seconded by Doreen Mulz to approve the Desert/Mountain Charter SELPA 2021-22 Annual Service Plan as

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presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

5.2 Desert/Mountain Charter SELPA Annual Budget Plan **(ACTION)**

California Education Code requires that an Annual Budget Plan be approved by the CAHELP JPA Governance Council as part of the Local Plan. The 2021-22 Annual Budget Plan describes the revenues and expenditures for special education services currently for all local education agencies in the Desert/Mountain Charter SELPA.

5.2.1 **BE IT RESOLVED** that a motion was made by Tanya Taylor, seconded by Doreen Mulz, to approve the Desert/Mountain Charter SELPA 2021-22 Annual Budget Plan as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.0 INFORMATION/ACTION

6.1 Proposed 2021-22 Desert/Mountain Charter SELPA Budget **(ACTION)**

The annual Desert/Mountain Charter SELPA budget for regional services administered by the SELPA office include the primary services provided through program specialists/regional services, X-pot, SELPA regional services, and DMCC. In reviewing and approving the budgets, the Desert/Mountain Charter Executive Council designates and supports the staff and operational expenses necessary to carry out the functions of the D/M Charter SELPA as designated in the Local Plans.

6.1.1 **BE IT RESOLVED** that a motion was made by Tanya Taylor, seconded by Debbie Tarver, to approve the Proposed 2021-22 Desert/Mountain Charter SELPA Budget as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.2 Proposed 2021-22 Desert/Mountain Charter SELPA Fee-for-Service Rates (**ACTION)**

Jenae Holtz called on Marina Gallegos to present the Proposed 2021-22 Desert/ Mountain Charter SELPA Fee-for-Service (FFS) Rates. Marina explained the rates apply to members that enter into an agreement with D/M Charter SELPA for services and is an off-the-top adjustment to the LEA Assembly Bill 602 Allocation. The 2021-22 rate is the prior year rate plus the 3.84% that was provided in the governor's budget. Marina said FFS reports are processed monthly and the annual rate is divided by 12, and if the student is current, the LEA is charged the twelfthly rate.

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6.2.1 **BE IT RESOLVED** that a motion was made by Tanya Taylor, seconded by Shawn Brumfield, to approve the 2021-22 Desert/Mountain Charter SELPA Proposed Fee-For-Service Rates as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.3 Low Incidence Reimbursement **(ACTION)**

Jenae Holtz proposed the use of increased low incidence funding to reimburse member LEAs for low incidence costs. She said there was a large increase in funding for low incidence equipment (LIE) that can be used to reimburse LEAs for their costs.

Marina Gallegos shared the projected LIE ending balance for 2020-21 is $60,293 of which she proposed 85% be spent to reimburse charter members for low incidence costs at the LEA level up to the maximum reimbursement cost presented. Marina continued that an invoice and supporting documentation would be submitted by the LEA to D/M SELPA. She said some funds would be retained in case new LEAs have students with low incidence disabilities or additional equipment needs.

Jenae said the D/M SELPA business office will work with LEAs regarding what supporting documents need to be submitted for reimbursement.

6.3.1 **BE IT RESOLVED** that a motion was made by Debbie Tarver, seconded by Tanya Taylor, to approve the increased low incidence funding will be used to reimburse member LEAs for low incidence costs as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.4 Desert/Mountain Charter SELPA Forms D/M 127 Assistive Technology Referral **(ACTION)**

Forms used in the operations of special education programs within the Desert/Mountain Charter SELPA are developed, reviewed and revised throughout the year upon the recommendation of the Program Team. Forms are modified as necessary in order to support the operations of special education programs in an efficient, effective and legally compliant manner. Suggested revisions to SELPA Forms are submitted to the D/M Charter SELPA Steering Committee for consideration and approval.

6.4.1 **BE IT RESOLVED** that a motion was made by Debbie Tarver, seconded by Tanya Taylor, to approve the Desert/Mountain Charter SELPA Form D/M 127 Assistive Technology Referral as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

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6.5 Desert/Mountain Charter SELPA Application for Membership FY 2021-22 **(ACTION)**

The Desert/Mountain Charter SELPA has received two applications from Virtual Preparatory Academy at Monterey and ASA Charter School for membership into the Charter SELPA for FY 2021-22. Jenae Holtz provided a summary of the applications for membership for both LEAs.

6.5.1 **BE IT RESOLVED** that a motion was made by Sebastian Cognetta, seconded by Shawn Brumfield, to approve the Virtual Preparatory Academy at Monterey application for membership as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.5.2 **BE IT RESOLVED** that a motion was made by Debbie Tarver, seconded by Sebastian Cognetta, to approve the ASA Charter School application for membership as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.6 CAHELP JPA Governance Council Representatives Fiscal Year 2021-22 **(ACTION)**

Article IV of the CAHELP JPA Bylaws specifies the CAHELP JPA Governance Council shall consist of two (2) CEO representatives from the Desert/Mountain Charter SELPA. The two Desert/Mountain Charter SELPA representatives will be chosen annually and will assume their roles as of July 1 of the next fiscal year. Discussion will center on the selection of these two representatives.

After brief discussion, a motion was made for Debbie Tarver and Sebastian Cognetta to continue as the representatives for fiscal year 2021-22.

6.6.1 **BE IT RESOLVED** that a motion was made by Lauren O'Neill, seconded by Tanya Taylor, for Debbie Tarver and Sebastian Cognetta be the two representatives for the CAHELP JPA Governance Council be approved as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

6.7 Desert/Mountain Charter SELPA Executive Council 2021-22 Meeting Dates and Times **(ACTION)**
Jenae Holtz presented dates and times of the 2021-22 Desert/Mountain Charter SELPA Executive Council Meetings.

6.7.1 **BE IT RESOLVED** that a motion was made by Lauren O'Neill, seconded by Tanya Taylor, to approve the dates and times of the 2021-22 Desert/Mountain Charter SELPA Executive Council Meetings as presented. A vote was taken and the following carried:

11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

7.0 CONSENT ITEMS

It is recommended that the Desert/Mountain Charter SELPA Executive Council consider approving several Agenda items as a Consent list. Consent Items are routine in nature and can be enacted in one motion without further discussion. Consent items may be called up by any Committee Member at the meeting for clarification, discussion, or change.

7.1 **BE IT RESOLVED** that a motion was made by Tanya Taylor, seconded by Debbie Tarver, to approve the following Consent Item as presented. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

7.1.1 Approve the January 14, 2021 Desert/Mountain Charter SELPA Executive Council Meeting Minutes.

8.0 CHIEF EXECUTIVE OFFICER AND STAFF REPORTS

8.1 Legislative Updates

Jenae Holtz presented the latest in State and Federal law related to students with disabilities and school law. She briefly reviewed multiple Assembly Bills (AB) and Senate Bills (SB).

Jenae called on Heidi Chavez to present information from State SELPA Administrators regarding Least Restrictive Environment and SB 692. Heidi said there are implications regarding deaf and hard of hearing students as well as visually impaired and blind students and the least restrictive environment is not always conducive to their needs. A team from State SELPA Administrators along with California School of the Deaf and California School of the Blind came together to write some language for an amendment to SB 692. The current bill would add the least restrictive environment, as measured by the percentage of pupils with individualized education programs who are 6 to 21 years of age, inclusive, served inside a regular classroom 80% or more of the day, as a state priority. Heidi continued the bill would require the state and local indicators for this state priority to be the same as the above-referenced federal indicator and would require the standards for these indicators to be consistent with the state's targets for the federal indicator. She said when it comes to a community regarding their language, the deaf, hard of hearing, and visually impaired students are not necessarily placed in their least restrictive environment. Heidi shared the amended language would be as follows: "These indicators and requirements, as needed, can be waived when working with low-incidence populations with special considerations, such as children who are deaf and hard of hearing (DHH), that require specialized services, special placement, and language support. In this case, a school for the deaf, regional program, or a more intensive setting

specifically designed to support the communication, language, and social-emotional development of students who are DHH would be a better option. Another example of a low-incidence population that may be eligible to be waived from these indicators and requirements are students who are blind or visually impaired that may require special placement to best serve their needs". Heidi concluded that it is felt it is best for students with low incidence needs is to be placed in a least restrictive environment of a school setting that meets their language needs as well as being with same age peers with learning and supports being available based on their needs.

8.2 State SELPA Administrators Information – Due Process

Jenae Holtz provided Due Process updates from State SELPA Administrators. She said there has been an uptick in complaints since January 2021 that are based on Covid-19 and what was not provided for children. Jenae provided some information on a case filed against Bakersfield City Elementary School District with the allegation that the district failed to provide Specialized Academic Instruction (SAI) or related services to any student with disabilities since closing its campuses due to Covid-19. In CDE's investigation, they sampled 25 students' services and IEPs while also reviewing logs for all students and found a lack of services clearly documented so the district was found out of compliance. Jenae reviewed the corrective actions which included a high level of monitoring of the Bakersfield City Elementary SD.

Jenae then spoke on a case filed against Travis Unified School District with the parent claiming their child did not receive the appropriate amount of speech services. Travis USD was able to show they had met the percentage of time based on the reduction in school time based on the law that was changed in SB 98 and prevailed in that case.

Jenae said the bottom line is documentation of how teachers track what they are doing, how they were presenting material, and how much time was spent on the lesson. When documentation is clear, some cases are being found in favor of the LEA. Jenae continued that when there is a lack of documentation, findings are in favor of the families and students. She said there are many case findings appearing to be based on the decision that Los Angeles Unified School District denied Free Appropriate Public Education (FAPE) during distance learning and the Administrative Law Judge (ALJ) determined services during closure constituted a material failure to implement the IEP. Jenae said it is important to keep track of service logs, emails, third party contracts. With third party contracts, LEAs must have the reports and documentation behind those services as well. Jenae concluded that D/M Charter SELPA is available to support the LEAs.

8.3 Management Information System (MIS) Web DA and Web IEP Standard Reports Manual

Jenae Holtz presented the Management Information System (MIS) Web DA and Web IEP Standard Reports Manual. She said typically for the charter schools, Colette Garland and Terri Nelson handle the LEA needs and data entry but the presented manual provides direction to CEO and directors on accessing student reports.

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8.4 CAHELP JPA Governance Council 2021-22 Meeting Dates

Jenae Holtz presented the CAHELP JPA Governance Council 2021-22 Meeting dates. Jenae reminded participants they all can attend the CAHELP JPA Governance Council Meetings though Debbie Tarver and Sebastian Cognetta do have the votes representing D/M Charter SELPA. Based on a suggestion from Debbie Tarver, the March meeting date will be revisited due to special education conferences and LEA spring breaks to possibly the end of February 2022.

8.5 988 National Crisis Hotline

Linda Llamas provided information pertaining to the future addition of the 988 National Crisis Hotline for mental health emergencies. She provided background in that the National Suicide Hotline Designation Act of 2020 was passed and is designed to set up the number 988 as the Universal Mental Health Crisis Hotline Telephone System and will be effective July 16, 2022. Linda said operators will have a special focus and training for populations with the highest risk of suicidal ideation and death by suicide which includes: Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) youth, American Indian Alaskan native individuals, and residents of rural counties. Didi Hirsch is the provider that will lead the California's lifeline crisis centers in developing a plan for coordination, capacity, funding, and communication surrounding the launch of 988. Linda also reported the County Behavioral Health Directors Association of California is forming work groups to provide recommendations and technical assistance for pending legislation and implementation. She said there are two bills being considered specifically for guiding further implementation of the roll out process. One bill is more detailed than the other and once one is passed, Linda will share the information to the committee as she receives it.

8.6 Professional Learning Summary

Heidi Chavez presented an update on the SELPA's professional development. She said for the month of March 2021, there were 14 participants at regional trainings. Heidi shared the year-to-date participants for on-site trainings is 32 with 130 regional attendees totaling 162 participants for the year.

Heidi reminded the meeting participants of the Directors' Training on April 16, 2021 at approximately 11:00am depending on adjournment of D/M SELPA Steering.

8.7 Resolution Support Services Summary

Jenae Holtz presented an update on the SELPA's resolution support services. She shared there are no new cases at this time. Jenae said it is important to focus on being prepared for due process that may occur around Covid-19 and being prepared for learning recovery by having discussions now with parents to avoid due process.

Kathleen Peters shared she is working with a D/M Charter SELPA LEA that is considering filing

on a parent because the student came to the school with an unsigned IEP from a local school district and the parent continues to not sign IEPs this year with the charter LEA.

Lauren O'Neill said directors of schools are tasked with many duties at this time of year along with reopening this year. She is concerned with the number of parents who do not want their children on Zoom but are no longer local to the LEA so they cannot attend in-person.

Kathleen said there should be a re-engagement plan with elements of a tiered system put in place. Then the next layer would be a Student Attendance Review Board (SARB) or other procedures to correct attendance concerns involving special education students and general education students.

Jenae stated the student handbook should address attendance expectations and suggested the handbook be modified if needed to include distance learning attendance and reasons for disenrollment.

Kathleen added LEAs are responsible to make the opportunities available but if the child is not made available by the family, the LEA is not responsible for the education missed but the LEA must document the efforts made to have the student participate in learning.

8.8 Compliance Updates

Jenae Holtz presented compliance updates. She reported CDE is focusing on two monitoring areas this year for late initial, annual, and triennial IEPs. Jenae continued LEAs will be placed in some level of monitoring, likely intensive. Significant disproportionality is also being monitored though none of the D/M Charter SELPA LEAs are in disproportionality.

Kami Murphy shared that the Prevention and Intervention team is doing work around equity and customized reports for reentry back into the school setting. She said if any additional supports or expertise is needed from Prevention and Intervention, contact her.

9.0 FINANCE COMMITTEE REPORTS

None.

10.0 INFORMATION ITEMS

11.0 DESERT/MOUNTAIN CHARTER SELPA EXECUTIVE COUNCIL MEMBERS COMMENTS / REPORTS

Debbie Tarver thanked Jenae Holtz for the support of CAHELP JPA.

12.0 CEO COMMENTS

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Jenae Holtz stated D/M Charter SELPA and CAHELP JPA are available to support and provide services to the LEAs wherever needed, including for students without disabilities and general education.

13.0 MATTERS BROUGHT BY CITIZENS

None.

14.0 ADJOURNMENT

Having no further business to discuss, a motion was made by Lauren O'Neill, seconded by Shawn Brumfield, to adjourn the meeting. A vote was taken and the following carried: 11:0: Ayes: Brumfield, Cognetta, Congo, Jung, Merrill, Mulz, Neuer, O'Neill, Romaine, Tarver, and Taylor. Nays: None, Abstentions: None.

The next regular meeting of the Desert/Mountain Charter SELPA Executive Council will be held on Thursday, October 21, 2021, at 10:00 a.m., at the Desert Mountain Educational Service Center, Aster/Cactus Room, 17800 Highway 18, Apple Valley, CA 92307.

Individuals requiring special accommodations for disabilities are requested to contact Jamie Adkins at (760) 955-3555, at least seven days prior to the date of this meeting.

From: Caitlin Jung
To:
Subject: Governor Signs Major K-12 Education Bills
Date: Friday, October 8, 2021 3:46:49 PM

With Sunday's signature deadline looming, this afternoon the Governor signed a number of high-profile K-12 education bills. Below is a highlight of the major bills signed into law today:

New Classified Layoff Notice Procedures. With relatively little fanfare, the Governor signed **AB 438** (Reyes, D – Grand Terrace) a labor-sponsored bill that, with few exceptions, provides classified employees with the same rights to layoff notice and hearing, and on the same timeline, as certificated employees. The bill also guarantees that any future rights to notice or hearings as to layoffs provided to certificated employees are also granted to classified staff. The bill will become effective on January 1, 2022.

Ethnic Studies Requirements. The Governor has signed **AB 101** (Medina, D – Riverside). LEAs serving grades 9-12 will now be required to offer at least a one-semester course in ethnic studies, beginning in the 2025-26 school year. The bill also adds the completion of a semester-long course in ethnic studies to the state high school graduation requirements, beginning with the 2029-30 school year. In his signing **message**, the Governor referenced studies that had shown access to ethnic studies courses boosted student achievement and ended the message by noting that, "Students deserve to see themselves in their studies and they must understand our nation's full history if we expect them to one day build a more just society."

Changes to *Williams* Inspection Criteria. The Governor also signed **AB 599** (Jones-Sawyer, D – Los Angeles), which updates the criteria used to identify schools for inspection by a county superintendent of schools for purposes of the *Williams* settlement. The original settlement identified schools for inspection if ranked in deciles 1-3 of the Academic Performant Index (API), but the API is outdated and was repealed in 2018. Under AB 599, schools will be identified if they meet any of the following criteria:

- All schools identified for comprehensive support and improvement (CSI) or additional targeted support and improvement (ATSI) under federal law.
- All schools where 15% or more of the teachers hold permits or certificates that are lesser certifications than a preliminary or clear California teaching credential.

2019-20 data will be used to create an initial 2021-22 fiscal year list of schools

to be inspected, which will be updated in 2022-23 and then every three fiscal years after that. However, the old API-Based list will still be used for the 2021-22 school year, with the new list of schools to be used by COEs after July 1, 2022.

Promoting Student Mental Health. The governor also signed a suite of bills to advance student mental health care and access, including **SB 224** (Portantino, D – La Cañada Flintridge), which requires schools offering one or more courses in health education to pupils in middle school or high school to include mental health instruction in those courses, and **SB 14** (Portantino), which adds "for the benefit of the pupil's mental or behavior health" to the definition of an excused absence due to a pupil's illness.

Bridging the digital divide. The Governor signed both **AB 14** (Cecilia Aguiar-Curry, D-Woodland), and **SB 4** (Lena Gonzalez, D-Long Beach), two high-profile bills changing the California Advanced Services Fund (CASF), one of the main sources of revenue for state-funded broadband projects. The surcharge that replenishes the CASF is set to expire at the end of 2022. The bills extend CASF through 2032 and allow a total yearly collection of up to $150 million. Both bills are "urgency" measures, meaning they immediately became law upon signature by the Governor.

These two bills, in combination with the three-year, $6 billion budget investment signed into law in **SB 156**, are purported to be able to get California most of the way to fully closing the digital divide. However, outstanding issues related to affordability of broadband services, for instance, may be examined by the Legislature in 2022.

What's next?

We will be sending out our annual "Changes in Education Law" series, covering all the education-related legislation that was signed into law this year, in the next few weeks. In the meantime, please reach out to anyone of us here at Capitol Advisors if you have any questions.

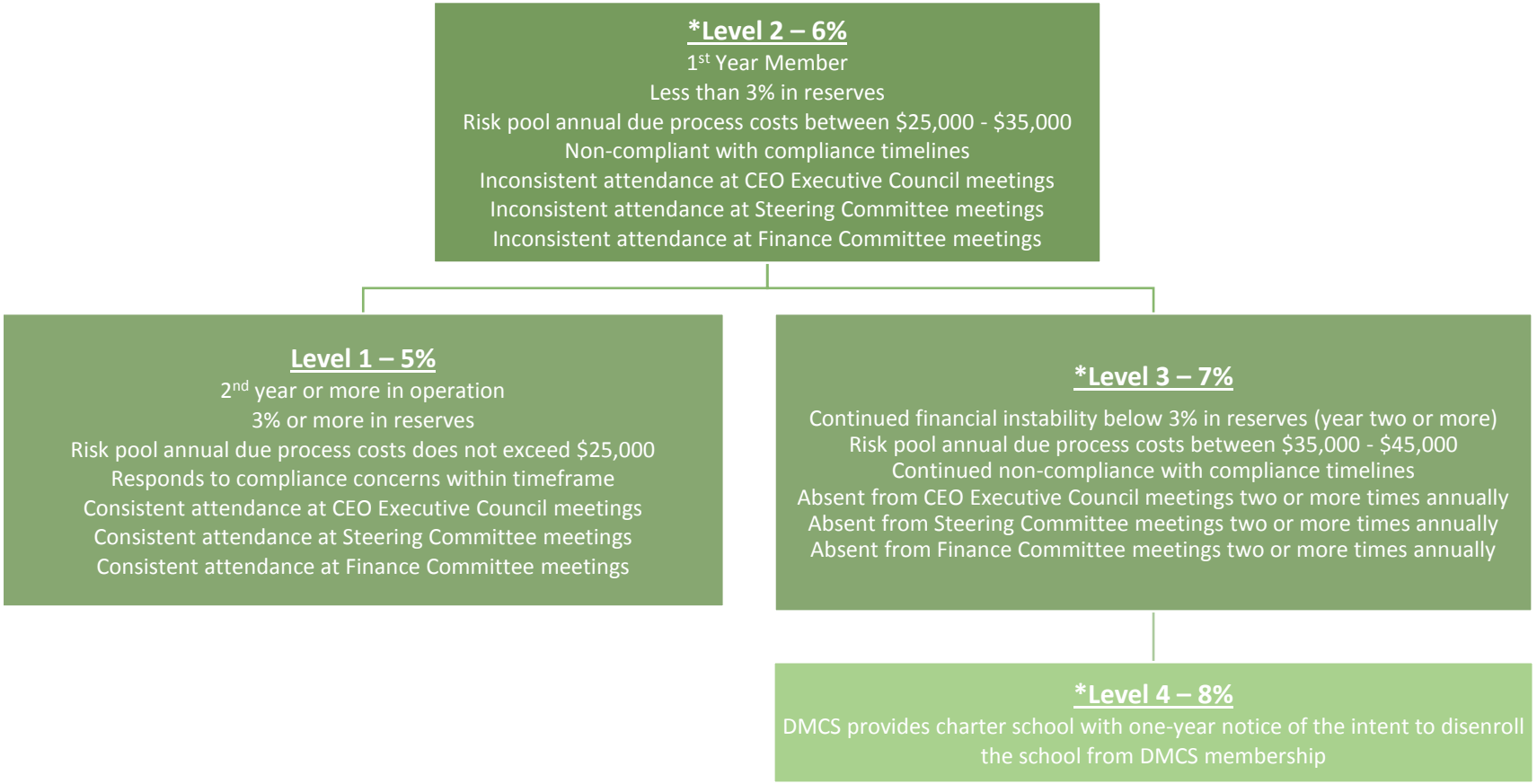
Best,
-Caitlin

Caitlin Jung
Legislative Counsel | Capitol Advisors Group

DESERT / MOUNTAIN
CHARTER SELPA

APPENDIX D

Desert/Mountain Charter SELPA
Risk Pool Flow Chart



For levels 2-4, one item will place you at this level

APPENDIX B: Non-Exclusive List of Qualified Examiners

Sources of Independent Evaluation by the Area of Assessment

(updated 10/2021)

The following is a non-exclusive list of public agencies and private individuals whom the Charter LEA has determined are qualified in their respective areas of assessment. The Charter LEA does not specifically endorse any listed agencies or individuals. Other agencies and individuals will be considered if they meet Charter LEA criteria. All private individuals who qualify under criteria established by the Charter LEA are encouraged to apply. The fee schedule will be used periodically to ensure parents the opportunity to choose from qualified assessors in the area.

Type of Assessor	Name and Contact Information
Assistive Technology	**Augmentative Communication Therapies** Cindy Cottier 3850 Startouch Dr. • Pasadena, CA 91106 (626) 351-5402 Email: cacottier@cacottier.com
Assistive Technology	**Hillside Therapy Inc.** Larry Silcock, OTR/L, Assistive Technology Specialist Alta Loma, CA 91737 (909) 208-8784
Assistive Technology	**Kouba Tech Solutions** Barbara J. Kouba P.O. Box 1106 • Helendale, CA 92342 (760) 784-5059 Email: bjkouba@gmail.com
Assistive Technology	**Orange County Goodwill – ATEC** Lauren Wetzler, Manager 1601 East St. Andrew Place • Santa Ana, CA 92705 (714) 361-6200, ext. 226 Email: atec@ocgoodwill.org Website: http://www.ocgoodwill.org/
Autism/Behavior	**Applied Behavior Consultants, Inc. (ABC)** 800 Ferrari Lane, Ste 100 • Ontario, CA 91764 (909) 484-2848, ext. 15 • (909) 484-3504 FAX Website: www.appliedbehaviorconsultants.com/
Autism/Behavior	**Autism Behavioral Consultants** 1880 Town & Country Rd., Ste B-101 • Norco, CA 92860 (951) 737-6300 • (951) 737-8779 FAX Website: www.autismbehaviorconsultants.net/

Type of Assessor	Name and Contact Information
Autism/Behavior	**Autism Spectrum Therapies, Inc**. 337 N. Vineyard Ave. • Ontario, CA 91764 28581 Old Town Front St. • Temecula, CA 92590 4719 Viewridge Ave., Ste 100, San Diego, CA 92123 147 E. Olive Ave. • Monrovia, CA 91016 (866) 727-8274 • (800) 459-4245 FAX Website: http://www.autismtherapies.com/
Autism/Behavior	**Behavioral and Education Support Team (BEST**) 411 S. Magnolia Ave. • El Cajon, CA 92020 (619) 442-1271 • (619) 444-8182 FAX Website: http://bestautismservices.com/
Autism/Behavior	**Center for Autism & Related Disorders (CARD)** 802 Magnolia Ave., Ste 202 • Corona, CA 92879 (951) 686-2020 • (951) 686-2120 FAX Website: http://www.centerforautism.com/
Autism/Behavior	**Desert/Mountain Children's Center (DMCC)** 17800 Highway 18 • Apple Valley, CA 92307 (760) 552-6700 • (760) 242-5363 FAX Website: http://www.cahelp.org/
Autism/Behavior	**El Paseo Children's Center** Palm Desert, California (760) 342-4900 Email: brent@epccsolutions.com Website: http://www.elpaseotesting.com/
Autism/Behavior	**LeafWing Center** 15972 Tuscola Rd., Ste 102 • Apple Valley, CA 92307 (760) 242-3353 • (760) 242-3332 FAX 13440 Ventura Blvd., Ste 200 • Sherman Oaks, CA 91423 (818) 442-0921 • (800) 832-2321 FAX Email: info@leafwingcenter.org Website: http://leafwingcenter.org/
Autism/Behavior	**People's Care Autism Services** 13901 Amargosa Rd., Ste 202 • Victorville, CA 92392 (760) 512-1925 • (760) 301-0097 FAX Website: http://www.peoplescare.com/autism-services
Autism/Behavior	**Specialized Therapy Services** Steven Oas Satellite Clinic: 2820 Roosevelt Rd., Ste 104 • San Diego, CA 92106 Main Clinic: 4204-A Adams Ave. • San Diego, CA 92116 (619) 252-4557 • (619) 431-5049 Website: https://www.theoascenter.com/

Type of Assessor	Name and Contact Information
ERMHS/Functional Behavior *(Bilingual/Spanish/English)*	**Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Website: www.neuroedclinic.com
Occupational/Physical Therapy	**Casa Colina Children's Services Center** Michele Alaniz, Clinical Director 255 East Bonita Ave. • Pomona, CA 91769 P.O. Box 6001 • Pomona, CA 91769 (909) 596-7733, ext. 4200 • (909) 596-3548 FAX Email: malaniz@casacolina.org Website: www.casacolina.org
Occupational/Physical Therapy	**Desert/Mountain Children's Center (DMCC)** 17800 Highway 18 • Apple Valley, CA 92307 (760) 552-65700 • (760) 242-5363 FAX Website: http://cahelp.org/
Occupational/Physical Therapy	**Horizon Therapy Services** Kathleen Pinto, OT 8265 White Oak Ave. • Rancho Cucamonga, CA 91730 (909) 373-1641 • (909) 481-7657 or 0444 FAX Email: info@horizontherapyservices.com Website: http://www.horizontherapyservices.com/
Neuro-Psychologist	**Susan Ferencz, Psy.D., ABSNP, LEP** 5101 E. La Palma Avenue, Ste 100D • Anaheim, CA 92807 (714) 337-9465 Email: sferenczpsyd@outlook.com
Neuro-Psychologist *(Bilingual/Spanish/English)*	**Veronica I. Olvera, Psy.D./Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Email: dr.veronica@neuroedclinic.com
Psychologist	**Doran A. Dula, Psy.D.** 250 West First St., Ste 352 • Claremont, CA 91711 (909) 624-TEST • (909) 626-4507
Psychologist	**Veronica Escoffery-Runnels, Ed.D.** University of LaVerne 1950 Third St. • LaVerne, CA 91750 (909) 593-3511, ext. 4387
Psychologist	**Susan Ferencz, Psy.D., ABSNP, LEP** 5101 E. La Palma Avenue, Ste 100D • Anaheim, CA 92807 (714) 337-9465 Email: sferenczpsyd@outlook.com
Psychologist	**Madison M. Kendrick, LMFT** Licensed Educational Psychologist, #3031 P.O. Box 2888 • Wrightwood, CA 92397 (760) 912-5780 Email: mmkendrick@msn.com

Type of Assessor	Name and Contact Information
Psychologist	**Richard J. Kleindienst, Ph.D.** 2823 Nevada Way • Riverside, CA 92506 (951) 660-8394
Psychologist	**Wendy Ness** Victorville, CA 92392 (760) 900-6845 Email: wendyness@outlook.com
Psychologist *(Bilingual/Spanish/English)*	**Veronica I. Olvera, Psy.D./Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Email: dr.veronica@neuroedclinic.com
Psychologist	**Federico Parres, Ph.D.** Etiwanda, CA (909) 241-8582
Psychologist	**Rebecca L. Parres** Etiwanda, CA (909) 938-2477
Psychologist	**Dr. Dudley Wiest** 1110 East Chapman, Ste 202 • Orange, CA 92866 (714) 744-9754 • (714) 744-1830 FAX Website: www.dudleywiestphd.com
Psychologist	**Desert/Mountain Children's Center (DMCC)** 17800 Highway 18 • Apple Valley, CA 92307 (760) 552-6700 • (760) 242-5363 FAX Website: http://cahelp.org/
Speech and Language	**Ardor Health Solutions, Inc.** 5830 Coral Ridge Dr., Ste 300 • Coral Springs, FL 33076 (866) 425-5768 • (888) 308-1147 Website: http://www.ardorhealth.com/
Speech and Language	**Augmentative Communication Therapies** Cindy Cottier 3850 Startouch Dr. • Pasadena, CA 91106 (626) 351-5402 Email: cacottier@cacottier.com *(NOTE: Evaluation does not include general special and language or articulation)*
Speech and Language	**Casa Colina Children's Services Center** Michele Alaniz, Clinical Director 255 East Bonita Ave. • Pomona, CA 91769 P.O. Box 6001 • Pomona, CA 91769 (909) 596-7733, ext. 4200 • (909) 596-3548 FAX Email: malaniz@casacolina.org Website: www.casacolina.org

Type of Assessor	Name and Contact Information
Speech and Language *(Bilingual/Spanish/English)*	**Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Website: www.neuroedclinic.com
Speech and Language	**Denise Parks, MA, CCC-SLP** Corona, CA 92883 (951) 347-0155 Email: couponqueenslp@gmail.com
Speech and Language	**Sound Therapies** Rachel Zijlstra 3551 Redwood St. • San Diego, CA 92104 (619) 641-7744 • (866) 547-8918 FAX Website: http://soundtherapiesinc.com/
Speech and Language	**Specialized Therapy Services** Steven Oas Satellite Clinic: 2820 Roosevelt Rd., Ste 104 • San Diego, CA 92106 Main Clinic: 4204-A Adams Ave. • San Diego, CA 92116 (619) 252-4557 • (619) 431-5049 Website: https://www.theoascenter.com/
Transition/Vocational	**Anjali Atkins-BizPop Transition Solutions** (562) 316-4859 Email: aatkins42@gmail.com
Transition/Vocational *(Bilingual/Spanish/English)*	**Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Website: www.neuroedclinic.com
Transition/Vocational	**Phyllis Perlroth-Picture What's Next** (858) 336-1857 Email: Phyllis.picturewhatsnext@gmail.com
~~Vision Assessment~~	~~**Ami Patel, O.D.**~~ ~~2771 S. Diamond Bar Blvd. • Diamond Bar, CA 91765~~ ~~(909) 598-4393~~
Vision Assessment	**Southern California College of Optometry** Eye Care Center at Fullerton Catherine Heyman, O.D. 2575 Yorba Linda Blvd. • Fullerton, CA 92831 (714) 992-7845 Email: cheyman@ketchum.edu Website: www.ketchumhealth.org

ANEXO B: Lista no exclusiva de evaluadores calificados

Tipo de asesor	Nombre e información de contacto
Tecnología de asistencia	***Augmentative Communication Therapies*** Cindy Cottier 3850 Startouch Dr. • Pasadena, CA 91106 (626) 351-5402 Correo electrónico: cacottier@cacottier.com
Tecnología de asistencia	***Hillside Therapy Inc.*** Larry Silcock, OTR/L, Especialista en tecnología de asistencia Alta Loma, CA 91737 (909) 208-8784
Tecnología de asistencia	***Kouba Tech Solutions*** Barbara J. Kouba P.O. Box 1106 • Helendale, CA 92342 (760) 784-5059 Correo electrónico: bjkouba@gmail.com
Tecnología de asistencia	***Orange County Goodwill – ATEC*** Lauren Wetzler, Gerente 1601 East St. Andrew Place • Santa Ana, CA 92705 (714) 361-6200, ext. 226 Correo electrónico: atec@ocgoodwill.org Sitio web: http://www.ocgoodwill.org/
Autismo/Conducta	***Applied Behavior Consultants, Inc. (ABC)*** 800 Ferrari Lane, Ste 100 • Ontario, CA 91764 (909) 484-2848, ext. 15 • (909) 484-3504 FAX Sitio web: www.appliedbehaviorconsultants.com/
Autismo/Conducta	***Autism Behavioral Consultants*** 1880 Town & Country Rd., Ste B-101 • Norco, CA 92860 (951) 737-6300 • (951) 737-8779 FAX Sitio web: www.autismbehaviorconsultants.net/
Autismo/Conducta	***Autism Spectrum Therapies, Inc.*** 337 N. Vineyard Ave. • Ontario, CA 91764 28581 Old Town Front St. • Temecula, CA 92590 4719 Viewridge Ave., Ste 100, San Diego, CA 92123 147 E. Olive Ave. • Monrovia, CA 91016 (866) 727-8274 • (800) 459-4245 FAX Sitio web: http://www.autismtherapies.com/

Tipo de asesor	Nombre e información de contacto
Autismo/Conducta	***Behavioral and Education Support Team (BEST)*** 411 S. Magnolia Ave. • El Cajon, CA 92020 (619) 442-1271 • (619) 444-8182 FAX Sitio web: http://bestautismservices.com/
Autismo/Conducta	***Center for Autism & Related Disorders (CARD)*** 802 Magnolia Ave., Ste 202 • Corona, CA 92879 (951) 686-2020 • (951) 686-2120 FAX Sitio web: http://www.centerforautism.com/
Autismo/Conducta	***Desert/Mountain Children's Center (DMCC)*** 17800 Highway 18 • Apple Valley, CA 92307 (760) 552-6700 • (760) 242-5363 FAX Sitio web: http://www.cahelp.org/
Autismo/Conducta	***El Paseo Children's Center*** Palm Desert, California (760) 342-4900 Correo electrónico: brent@epccsolutions.com Sitio web: http://www.elpaseotesting.com/
Autismo/Conducta	***LeafWing Center*** 15972 Tuscola Rd., Ste 102 • Apple Valley, CA 92307 (760) 242-3353 • (760) 242-3332 FAX 13440 Ventura Blvd., Ste 200 • Sherman Oaks, CA 91423 (818) 442-0921 • (800) 832-2321 FAX Correo electrónico: info@leafwingcenter.org Sitio web: http://leafwingcenter.org/
Autismo/Conducta	***People's Care Autism Services*** 13901 Amargosa Rd., Ste 202 • Victorville, CA 92392 (760) 512-1925 • (760) 301-0097 FAX Sitio web: http://www.peoplescare.com/autism-services
Autismo/Conducta	***Specialized Therapy Services*** Steven Oas Clínica satélite: 2820 Roosevelt Rd., Ste 104 • San Diego, CA 92106 Clínica principal: 4204-A Adams Ave. • San Diego, CA 92116 (619) 252-4557 • (619) 431-5049 Sitio web: https://www.theoascenter.com/
ERMHS/Comportamiento funcional *(Bilingüe/Español/Inglés)*	**Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Sitio web: www.neuroedclinic.com
Terapia ocupacional / física	***Casa Colina Children's Services Center*** Michele Alaniz, l Director clínico 255 East Bonita Ave. • Pomona, CA 91769 P.O. Box 6001 • Pomona, CA 91769 (909) 596-7733, ext. 4200 • (909) 596-3548 FAX Correo electrónico: malaniz@casacolina.org

Tipo de asesor	Nombre e información de contacto
	Sitio web: www.casacolina.org
Terapia ocupacional / física	***Desert/Mountain Children's Center (DMCC)*** 17800 Highway 18 • Apple Valley, CA 92307 (760) 552-65700 • (760) 242-5363 FAX Sitio web: http://cahelp.org/
Terapia ocupacional / física	***Horizon Therapy Services*** Kathleen Pinto, OT 8265 White Oak Ave. • Rancho Cucamonga, CA 91730 (909) 373-1641 • (909) 481-7657 o 0444 FAX Correo electrónico: info@horizontherapyservices.com Sitio web: http://www.horizontherapyservices.com/
Neurosicólogo	**Susan Ferencz, Psy.D., ABSNP, LEP** 5101 E. La Palma Avenue, Ste 100D • Anaheim, CA 92807 (714) 337-9465 Correo electrónico: sferenczpsyd@outlook.com
Neurosicólogo *(Bilingüe/Español/Inglés)*	**Veronica I. Olvera, Psy.D./Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Correo electrónico: dr.veronica@neuroedclinic.com
Sicólogo	***Doran A. Dula, Psy.D.*** 250 West First St., Ste 352 • Claremont, CA 91711 (909) 624-TEST • (909) 626-4507
Sicólogo	***Veronica Escoffery-Runnels, Ed.D.*** University of LaVerne 1950 Third St. • LaVerne, CA 91750 (909) 593-3511, ext. 4387
Sicólogo	**Susan Ferencz, Psy.D., ABSNP, LEP** 5101 E. La Palma Avenue, Ste 100D • Anaheim, CA 92807 (714) 337-9465 Correo electrónico: sferenczpsyd@outlook.com
Sicólogo	***Madison M. Kendrick, LMFT*** Sicóloga educativa certificada, #3031 P.O. Box 2888 • Wrightwood, CA 92397 (760) 912-5780 Correo electrónico: mmkendrick@msn.com
Sicólogo	***Richard J. Kleindienst, Ph.D.*** 2823 Nevada Way • Riverside, CA 92506 (951) 660-8394
Sicólogo	***Wendy Ness*** Victorville, CA 92392 (760) 900-6845 Correo electrónico: wendyness@outlook.com

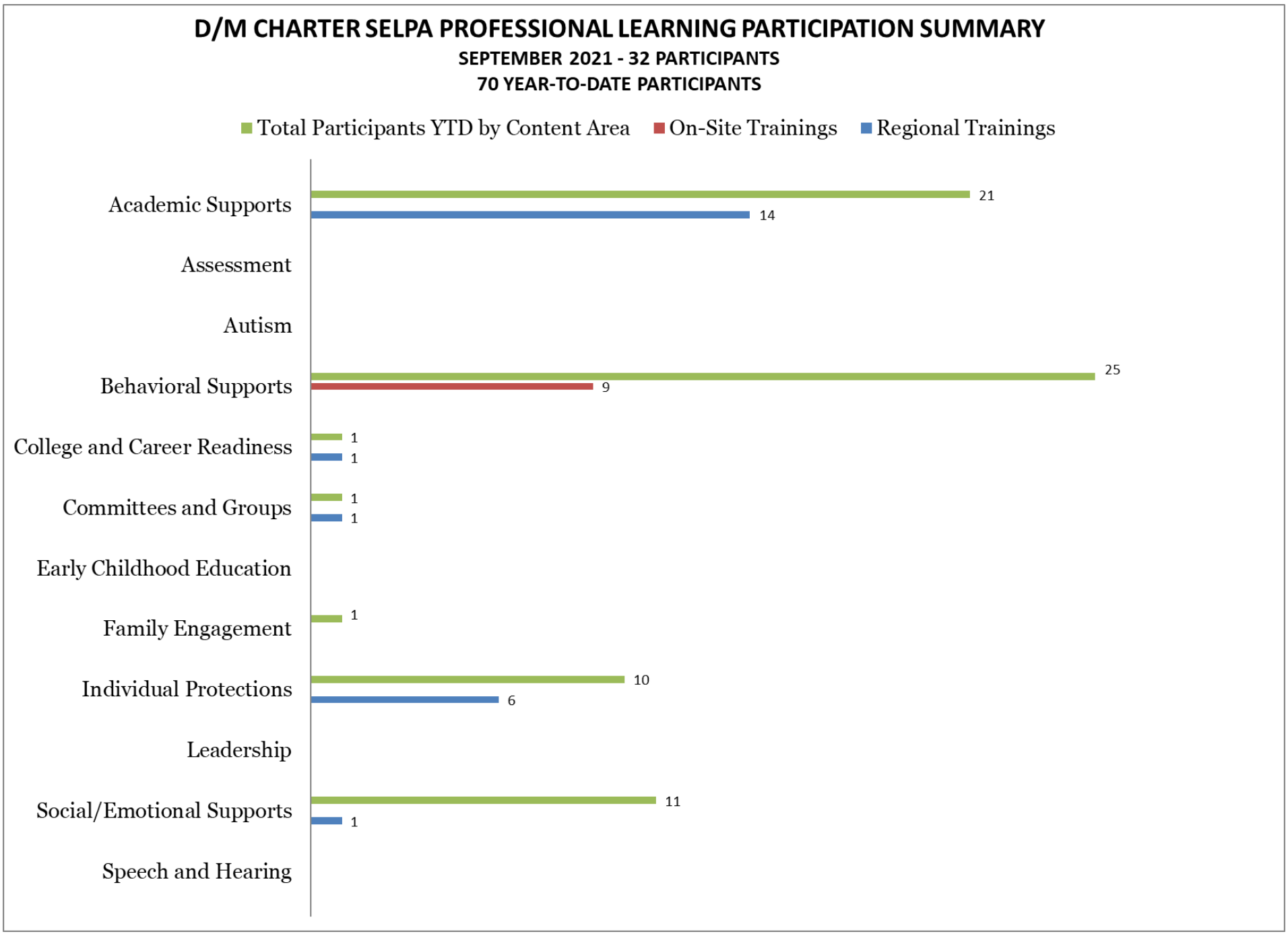
Tipo de asesor	Nombre e información de contacto
Sicólogo *(Bilingüe/Español/Inglés)*	**Veronica I. Olvera, Psy.D./Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Correo electrónico: dr.veronica@neuroedclinic.com
Sicólogo	***Federico Parres, Ph.D.*** Etiwanda, CA (909) 241-8582
Sicólogo	***Rebecca L. Parres*** Etiwanda, CA (909) 938-2477
Sicólogo	***Dr. Dudley Wiest*** 1110 East Chapman, Ste 202 • Orange, CA 92866 (714) 744-9754 • (714) 744-1830 FAX Sitio web: www.dudleywiestphd.com
Sicólogo	***Desert/Mountain Children's Center (DMCC)*** 17800 Highway 18 • Apple Valley, CA 92307 (760) 552-6700 • (760) 242-5363 FAX Sitio web: http://cahelp.org/
Habla y lenguaje	***Ardor Health Solutions, Inc.*** 5830 Coral Ridge Dr., Ste 300 • Coral Springs, FL 33076 (866) 425-5768 • (888) 308-1147 Sitio web: http://www.ardorhealth.com/
Habla y lenguaje	***Augmentative Communication Therapies*** Cindy Cottier 3850 Startouch Dr. • Pasadena, CA 91106 (626) 351-5402 Correo electrónico: cacottier@cacottier.com *(NOTA: La evaluación no incluye evaluación especial general y lenguaje o articulación)*
Habla y lenguaje	***Casa Colina Children's Services Center*** Michele Alaniz, Directora clínica 255 East Bonita Ave. • Pomona, CA 91769 P.O. Box 6001 • Pomona, CA 91769 (909) 596-7733, ext. 4200 • (909) 596-3548 FAX Correo electrónico: malaniz@casacolina.org Sitio web: www.casacolina.org
Habla y lenguaje *(Bilingüe/Español/Inglés)*	**Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Sitio web: www.neuroedclinic.com
Habla y lenguaje	***Denise Parks, MA, CCC-SLP*** Corona, CA 92883 (951) 347-0155 Correo electrónico: couponqueenslp@gmail.com

Tipo de asesor	Nombre e información de contacto
Habla y lenguaje	***Sound Therapies*** Rachel Zijlstra 3551 Redwood St. • San Diego, CA 92104 (619) 641-7744 • (866) 547-8918 FAX Sitio web: http://soundtherapiesinc.com/
Habla y lenguaje	***Specialized Therapy Services*** Steven Oas Clínica satélite: 2820 Roosevelt Rd., Ste 104 • San Diego, CA 92106 Clínica principal: 4204-A Adams Ave. • San Diego, CA 92116 (619) 252-4557 • (619) 431-5049 Sitio web: https://www.theoascenter.com/
Transición / Vocacional	***Anjali Atkins-BizPop Transition Solutions*** (562) 316-4859 Correo electrónico: aatkins42@gmail.com
Transición / Vocacional *(Bilingüe/Español/Inglés)*	**Neuro-Educational Clinic** 6809 Indiana Avenue, Ste 131 • Riverside, CA 92506 (951) 266-6223 • Fax: (951) 267-2536 Website: www.neuroedclinic.com
Transición / Vocacional	***Phyllis Perlroth-Picture What's Next*** (858) 336-1857 Correo electrónico: Phyllis.picturewhatsnext@gmail.com
~~Evaluación visual~~	~~***Ami Patel, O.D.***~~ ~~2771 S. Diamond Bar Blvd. • Diamond Bar, CA 91765~~ ~~(909) 598-4393~~
Evaluación visual	***Southern California College of Optometry*** Centro de atención ocular en Fullerton Catherine Heyman, O.D. 2575 Yorba Linda Blvd. • Fullerton, CA 92831 (714) 992-7845 Correo electrónico: cheyman@ketchum.edu Sitio web: www.ketchumhealth.org

D/M CHARTER SELPA PROFESSIONAL LEARNING PARTICIPATION SUMMARY

SEPTEMBER 2021 - 32 PARTICIPANTS

70 YEAR-TO-DATE PARTICIPANTS



Desert/Mountain Charter SELPA
Due Process Summary
July 1, 2021 - October 21, 2021

D = Complaint Dismissed W = Complaint Withdrawn

DISTRICT											CASE ACTIVITY FOR CURRENT YEAR				
	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	Total		D /W	Resolution	Mediation	Settled	Hearing
Allegiance STEAM Acad - Thrive	N/A	N/A	N/A	N/A	0	0	0	0	0		0	0	0	0	0
Aveson Global Leadership Acad	N/A	2	1	5	1.5	0	0	2	11.5		0	2	0	0	0
Aveson School of Leaders	N/A	0	3	1	1.5	0	0	2	7.5		0	2	0	0	0
Ballington Acad for Arts & Sci	N/A	N/A	N/A	0	2	0	0	0	2		0	0	0	0	0
Desert Trails Prep Academy	0	0	0	0	0	0	0	0	0		0	0	0	0	0
Elite Academic Acad - Lucerne	N/A	N/A	N/A	N/A	0	0	4	0	4		0	0	0	0	0
Encore Junior/Senior High School	0	0	0	0	0	0	0	0	0		0	0	0	0	0
Julia Lee Performing Arts Acad	N/A	N/A	N/A	N/A	0	0	0	0	0		0	0	0	0	0
LaVerne Elem Preparatory	0	0	0	0	0.5	0	0	0	0.5		0	0	0	0	0
Leonardo da Vinci Health Sci	0	0	0	0	0	0	0	0	0		0	0	0	0	0
Odyssey Charter School (Altadena)	N/A	0	0	0	0	0	0	1	1		0	0	0	1	0
Odyssey Charter School -South (Pasadena)	N/A	N/A	N/A	N/A	0	0	0	0	0		0	0	0	0	0
Pasadena Rosebud Academy	N/A	N/A	N/A	N/A	1	0	0	0	1		0	0	0	0	0
Pathways to College	0	0	0	0	0	0	0	0	0		0	0	0	0	0
Taylion High Desert Academy	0	0	0	0	0	0	0	0	0		0	0	0	0	0
Virtual Prep Academy at Lucerne	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0		0	0	0	0	0
SELPA-WIDE TOTALS	**0**	**2**	**4**	**6**	**6.5**	0	**4**	**5**	**27.5**		**0**	**4**	**0**	**1**	**0**

Desert/Mountain Charter SELPA
Due Process Activity Summary
July 1, 2021–October 21, 2021

LEA Case Number	Issue(s)	Date Filed	Resolution Scheduled	Mediation Scheduled	Pre-Hearing Conference	Due Process Hearing	Status
1. Odyssey Charter Case No. 2021070313	Child Find and Denial of FAPE: 1. Failed to appropriately assess in all areas of suspected need (AT, OT) 2. Failure to qualify for SPED 3. Lack of parental participation 4. Substantively deny FAPE	7/19/21	7/28/21		9/3/2021	~~9/14 - 9/16/2021~~	Effective upon full execution of the settement agreement on 8/23/2021: Reimburse Parents for educational and counseling expenses - $5,069.00. **Settlement Agreement - CASE CLOSED**
2. Aveson Case No. 2021080796	Denial of FAPE: 1. Failure to provide appropriate program and adequate support. 2. Denial of parental participation. 3. Lack of educational benefit	8/25/2021	9/9/2021		10/11/2021	10/19 - 10/21/2021	Parent unrepresented at Resolution. No settlement.
3. Aveson Case No. 2021090088	Denial of FAPE: 1. Failure to assess in all areas of suspected need / TRI 2. Failure to provide appropriate program and adequate support. 3. Inappropriate placement and services. 4. Failure to offer a BIP	9/2/2021	~~9/14/2021~~ 9/20/2021		10/18/2021	10/26-27/2021	Parent seeking private school placement and reimbursement for unilateral placement. No settlement

Desert/Mountain Charter SELPA
Due Process Activity Summary
July 1, 2021–October 21, 2021

LEA Case Number	Issue(s)	Date Filed	Resolution Scheduled	Mediation Scheduled	Pre-Hearing Conference	Due Process Hearing	Status
4. Aveson Case No. 2021090785	Child Find and Denial of FAPE: 1. Impeded participation 2. Assessment not thorough 3. Lack of Ed benefit 4. Discrimination	9/23/2021	10/5/2021				No settlement, will go to mediation.
5. Aveson Case No. 2021	Denial of FAPE: 1. Inadequate assessments, PLOPS/goals, services program and placement. 2. Failed to implement IEP during distance learning. 3. Failed to provide prior written notice. 4. Unclear offer of FAPE. 5. Predetermination. 4. Impede parent participation.	10/1/2021	~~10/7/2021~~				

Desert /Mountain Charter SELPA
Legal Expense Summary
As Reported at Steering October 21, 2021

2000-2001	0.00
2001-2002	0.00
2002-2003	0.00
2003-2004	0.00
2004-2005	0.00
2005-2006	0.00
2006-2007	0.00
2007-2008	0.00
2008-2009	0.00
2009-2010	0.00
2010-2011	0.00
2011-2012	0.00
2012-2013	0.00
2013-2014	0.00
2014-2015	0.00
2015-2016	7,378.00
2016-2017	33,886.61
2017-2018	70,994.67
2018-2019	113,834.81
2019-2020	58,033.90
2020-2021	43,640.20
2021-2022	53,256.09

7.6 Compliance Update

Verbal report, no materials