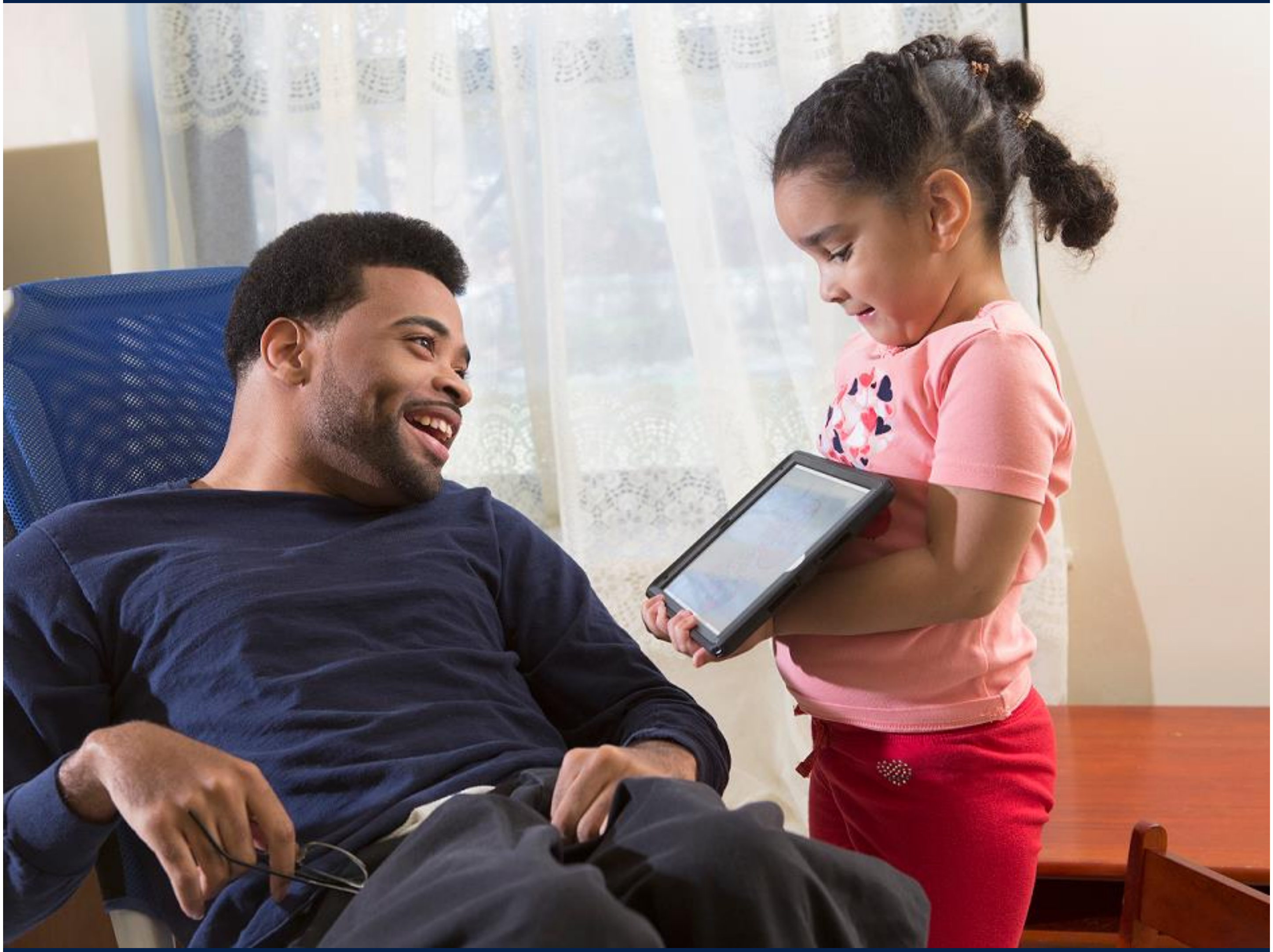
Everybody Communicates:

A Toolkit for Accessing Communication Assessments, Funding, and Accommodations



Office of Developmental Primary Care

Improving outcomes for people with developmental disabilities

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1: Introduction and How to Use This Toolkit

This toolkit, created by the Autistic Self Advocacy Network, is designed to help you access communication evaluations and tools for effective communication for people with communication-related developmental disabilities.[1] These may include autism, apraxia, cerebral palsy, and other developmental disabilities that affect communication.

References:

[1] Autistic Self Advocacy Network. Available at: www.autisticadvocacy.org. Accessed 01/18/2018.

Everybody Communicates!

People sometimes assume that people with communication-related disabilities don't want to communicate or can't communicate. This assumption can prevent people from getting the supports they need. But everybody communicates - whether using language, behavior, gestures, facial expressions, sounds, or other means.

People with communication-related disabilities are also often harmed by low expectations. While teaching simple requests, numbers, and greetings may be appropriate for very young children, older children and adults with communication-related disabilities need to have access to a much wider range of human expression - including the ability to ask questions and make statements about the past and future.

Why is Communication Important?

Effective communication is necessary for success in almost every aspect of life.

- Health: Without effective communication, people may be unable to explain their symptoms or understand how to follow doctors' instructions.
- Self-determination: Effective communication can help individuals express preferences and make decisions, from preferred meals to housing and major healthcare decisions.
- Person-centered planning: Effective communication can help ensure that individuals have input when planning their services and supports. This not only helps promote autonomy and self-determination but can also help identify which supports are needed and which are likely to work.

What Do Good Communication Supports Look Like?

In order to gain that access, people with communication-related disabilities need the right supports.

First, supporters must presume competence. If a person isn't able to do much more than say individual words or make basic requests, supporters shouldn't assume that that's because they have nothing else to say. Instead, assume that this means that they haven't yet figured out the right supports that work for them.

Second, supporters need to be persistent. It can take time for people to learn how to use a communication system. And if a communication support system isn't working even after a reasonable learning period, try another!

Supporters need to get the right training. Imagine trying to learn a language from teachers who don't know that language very well themselves. Communication is a two-way street - without a fluent communication partner, it will not be possible for individuals to become fluent themselves.

Supporters need to pay attention to both expressive and receptive communication. It is just as important to learn how to understand others, as it is to learn how to express oneself. Focusing on only one of these two domains will not necessarily improve a person's skills in the other domain.

A “Total Approach” to Communication

Communication touches on all aspects of a person's life. It's therefore important to take a "total approach" to communication. This means:

- Ensuring that individuals have access to their preferred mode of communication at all times, not just in certain programs or situations
- Recognizing and responding to all forms of communication a person uses
- Ensuring that individuals always have access to communication partners and supporters who understand the way they communicate
- Ensuring that individuals have access to open-ended forms of communication to the greatest extent possible and are not limited to pre-selected words or phrases

Where Can I Get Communication Supports?

Effective communication evaluations, tools, and supports may be available through:

- Health insurance (including Medi-Cal)
- School programs
- Vocational Rehabilitation programs
- Regional Centers
- The Americans with Disabilities Act

This guide will help you navigate these systems to access communication supports.

2: Assessments

The first step in finding and getting communication supports is getting a good assessment.

An assessment requires a professional to interact with a person who has a communication impairment and identify:

1. Which challenges the person may face when communicating, including:
    - Sensory impairments
    - Motor impairments
    - Cognitive impairments
2. What forms of communication the individual already uses
3. How to support the individual to communicate more effectively

This part of the guide will explain the elements of a good assessment. It will also explain how to choose a professional to conduct the assessment and provide links to guides to getting programs to pay for assessments.

Components of a Good Assessment

Identify which challenges the person may face when communicating

A good assessment will start by identifying barriers to communication. These may include:

Sensory impairments

- Hearing: Can the individual hear?
- Auditory processing: Can the individual distinguish different kinds of speech sounds from others?
- Vision: Can the individual see?
- Visual Processing: Can the individual recognize body language, easily distinguish and locate symbols, distinguish between different signs and gestures, etc.?
- Proprioception: Can the individual tell where his or her body is in space?

Motor impairments

- Motor strength: Can the individual move the muscles that are required for speech, sign language, pointing, gesturing, or typing?
- Motor skill: has the individual learned how to move his or her muscles as is needed to produce specific speech sounds, accurately point to items or tap accurately on letter keys?
- Dyspraxia/Apraxia: Can the individual control the muscles that are required for speech or sign language, pointing, gesturing, or typing?
- Motor planning and initiation: Can the individual begin the necessary movements on his or her own, or does he or she need to be prompted in some way? Can the individual carry out a

complicated sequence of movements (including a sequence of spoken sounds as needed to make words, or a sequence of hand movements as needed to sign, type, or write?)

Cognitive impairments

- Can the individual remember and recall words and their meanings? Does the individual need extra time to recall words?
- Can the individual recognize letters and symbols?
- Can the individual follow complicated sentences or instructions?

When a person has developmental disabilities, professionals often assume that all communication difficulties are the result of cognitive impairments. This is not true. Many developmental disabilities, including autism, apraxia, and cerebral palsy, come from motor or sensory impairments. A competent communication assessment must address all three types of impairments: sensory, motor, and cognitive.

Remember, motor and sensory impairments are easily mistaken for cognitive impairments. In the past, many Deaf children were assumed to be intellectually disabled because they could not use spoken language in the same way as hearing children. This assumption led adults to simply give up on providing an acceptable alternative form of communication, a decision that led to disastrous consequences for Deaf individuals. It is less dangerous to presume that an individual has sensory or motor challenges, and try different approaches that could address those challenges, before assuming that all communication difficulties result from a cognitive impairment.

Identify which forms of communication the individual already uses

Everyone communicates. Even if a person does not appear to be communicating on purpose, there are probably ways that the person can communicate feelings or wants. The assessor should interact with the individual and the individual’s support network in order to determine how the individual uses:

- Spoken words
- Signed words (e.g., American Sign Language, Simplified Sign Language, Signed English, or finger-spelling)
- Gestures, sounds, facial expressions, or body language
- Behavior (e.g., moving towards or away from a person or situation, hitting, grabbing, etc.)
- Typing or spelling
- Pointing at objects
- Choosing pictures or symbols (e.g., PECS)

Make recommendations on how to support the individual to communicate more effectively

The assessment should conclude with recommendations to help a person communicate more effectively. These can include:

- Introducing forms of communication that compensate for motor or sensory impairments. These might include signing, spelling, pointing, prompting, and/or use of technology or ergonomic supports.
- Strategies that help build vocabulary and strengthen word recall.
- Occupational, physical, or speech therapy to help strengthen communication skills.
- Training the individual's regular communication partners (e.g., parents, family members, teachers, and classmates) to implement communication supports.

A good assessment should include multiple options to try. Keep in mind that nobody, with or without disabilities, uses only one form of communication. Typically, people without disabilities will communicate through a combination of speech, signs, gestures, typing, writing, pointing, and behavior, depending on the situation. The focus should be on ensuring that a person's communication is as effective as possible - not on forcing a person to communicate in only one or two ways.

> **Literacy Instruction.** Keep in mind that any form of communication that involves spelling or typing must be accompanied by literacy instruction!

Choosing an Assessment Professional

The key to obtaining a quality communication assessment is choosing the right professional. Make sure that the professional is qualified to evaluate people with developmental disabilities. The professional also should be committed to presuming competence and be familiar with a wide range of possible communication supports.

Here are some questions that you should ask when deciding whether to use a professional for a communication assessment:

What is the professional's educational background?

Generally, the person conducting a communication assessment will be a psychologist or speech-language pathologist.

What is the professional's specialty?

A good communication assessment must be done by someone who specializes in communication and language development - not someone whose primary training is in behavior modification or analysis, or someone whose expertise is in only one kind of communication method.

Is the professional a member of relevant professional associations?

These may include The American Speech-Hearing Association or The American Occupational Therapy Association.[1, 2]

References:

[1] The American Speech-Hearing Association. Available at: www.asha.org. Accessed 01/18/2018.

[2] The American Occupational Therapy Association. Available at: https://www.aota.org/. Accessed 01/18/2018.

Does the professional have conflicts of interest?

These may include a business interest in a specific communication method or tool. They also may include a close financial relationship to the entity that will be paying for the communication supports, such as a school district or vocational rehabilitation office.

Does the professional understand the importance of presuming competence and including motor and sensory challenges in all assessments?

It is critical that the professional be willing to presume competence. The professional should not assume that all of the individual's communication challenges are caused by cognitive or intellectual impairment - even when the individual has been diagnosed with a cognitive or intellectual disability.

> **List of AAC Providers in California.** If you are looking for an AAC assessment, you can check AbilityTools.org, run by California's Tech Act Project, for a list of AAC providers in California.[1] This list is not a list of endorsed or recommended providers - it simply is a list of providers who have told the Tech Act Project that they do AAC assessments. Make sure to contact each provider for information on their practice and qualifications before picking a provider.

References:

[1] AAC Providers in California. Available at: http://abilitytools.org/resources/aac-assessments.php. Accessed on 01/18/2018.

Paying for the Assessment

Assessments can be expensive if they are paid for out-of-pocket. Fortunately, it's possible to get funding for communication assessments from a variety of sources. This toolkit includes guides for obtaining assessments through:

Health insurance, including

- Medi-Cal for People under Age 21
- Traditional Medi-Cal
- Private health insurance

School districts, using the Individuals with Disabilities Education Act (IDEA)

- IDEA Part B (Individuals ages 3-21)
- IDEA Part C (Individuals ages birth through 2 years)
- Vocational Rehabilitation Programs
- Regional Centers

3: Choosing Communication Supports

The right communication supports can make an enormous difference in the life of a person with a communication-related disability. It is important to ensure that people with communication-related disabilities have access to supports that are tailored to their particular needs and preferences. It may be necessary to continually evaluate the communication supports a person uses and adjust those supports, starting in early childhood and continuing through early adulthood.

Types of Possible Supports

Supports may include:

- Speech-Language therapy
- Physical therapy
- Occupational therapy
- Specialized literacy or language instruction
- Augmentative and alternative communication (AAC) tools or technology
- Low-technology communication supports, including interpreters

People may use just one of these supports or may use a combination of many supports.

Speech-Language Therapy

Speech-Language Therapy is typically delivered by a speech therapist or speech-language pathologist. While many people assume that speech-language therapy is focused on training people to speak orally, speech-language therapy also can include training in use of augmentative and alternative communication (AAC) tools or technology. This may be particularly important when individuals have motor disabilities that make it difficult to speak.

Speech-language therapy may also include:

- Help with learning how to understand speech
- Training for an individual's family members and teachers in how to support an individual in learning language and communicating effectively.

Physical Therapy

Physical Therapy is typically delivered by a licensed physical therapist. Although physical therapists tend not to focus on the motor skills necessary for speech, they may help an individual develop motor skills that are necessary for other forms of communication, such as pointing, handling objects, using gestures, writing, or typing.

Occupational Therapy

Occupational Therapy helps people gain skills that they need in order to perform activities of daily living, which can include communication. It is typically delivered by licensed occupational therapists. Occupational therapy can help people develop communication-related skills like writing, pointing, using a letterboard or keyboard, controlling eye gaze, or using other forms of augmentative and alternative communication (AAC).

Literacy and Language Instruction

People with communication-related disabilities need the same access to literacy instruction as those without disabilities. Literacy and language instruction may significantly open up an individual's options for communication. For example, a person who has trouble speaking may, with appropriate literacy instruction, learn to type or spell using a letter board or keyboard. This in turn may help the individual use the full range of his or her primary language, instead of having to rely on picture-based forms of communication.

Supporters should never assume that someone cannot learn literacy skills based on the individual's measured IQ or ability to speak. In some cases, people with developmental disabilities learn to read before they learn to speak.

Literacy and language instruction may need to be tailored to an individual's particular disability-related needs. For example, people who have trouble distinguishing words from each other may need extra support and one-on-one instruction that typically developing individuals would not need. People who have difficulty speaking may need their language instruction to be paired with AAC training.

It is important that language and literacy instruction begin early. In general, children are thought to learn language most easily before the age of five, and ideally should be exposed to a language-rich environment as early as possible. Even if an individual has not demonstrated language use before adulthood, however, it can still be worthwhile to invest in language and literacy instruction.

Augmentative and Alternative Communication (AAC) Tools or Technology

People with communication-related disabilities may benefit from augmentative and alternative communication (AAC). These can range from very high-tech speech-generating devices to very simple tools, such as a pre-printed letter board. There is no one form of AAC that works for everyone.

How to Choose Supports

It can be difficult to decide which services and supports to try. Many people try a wide range of different services and supports before finding one that works. You may want to consider:

- The recommendations of any communication assessments that have been performed
- The individual's or family's perceptions about which needs are most important
- Availability of coverage for the support (see Chapter 4 for more information):
  - Private health insurance
  - Medicaid EPSDT programs for people under age 21
  - Medi-Cal for adults
  - Private health insurance
  - IDEA Part B for people ages 3-21
  - IDEA Part C for children from birth through age 2
  - Vocational Rehabilitation
  - Regional Centers
  - The Americans with Disabilities Act

Choosing an Intervention and Provider

If you are considering interventions such as speech-language therapy or occupational therapy, it is important to carefully consider which intervention to use.

Depending on the source of coverage, you may need to bring in an interdisciplinary team to help decide on a service or technology. For example, if you are seeking interventions through the IDEA, the intervention needs to be agreed upon by a team that includes the parent, teachers, administrators, other service providers, and if age-appropriate, the student.

It can be tempting for service providers to have a set of "go-to" services to recommend for people with a particular diagnosis. This is not necessarily a good approach.

Instead, parents, service providers, and teams should consider:

- What are the specific challenges that the individual is facing with respect to communication?
- Which approach would enable the individual to communicate as fast as possible?
  - People who are not yet literate may benefit from communication supports that do not require literacy, while they are working toward literacy goal
  - People who have difficulty with the motor control necessary for speech may benefit from AAC that does not require fine motor control - even if improving speech production is a goal
- Is there a provider in your area who has particular expertise in working with people with similar needs or using a particular intervention method?
- What kind of time commitment can the individual, family, and service providers make?
- Is the intervention available in the individual's school, home, or immediate community?
- Are all relevant stakeholders - including the individual, family, and other service providers, "on board" with the intervention?

Choosing an AAC Method

When choosing AAC tools or technology to try, you should *also* consider:

Ability to use the tool across a variety of settings

- If the AAC is a standalone piece of equipment, is it portable? Does it work across settings?
- If the AAC requires the help of a supporter to use, are trained supporters available across a variety of settings?
- Are there providers in the area who are capable of teaching the individual, family, and service providers how to use it?

Availability of AAC across settings is important to helping people become proficient at using it. It is difficult to learn any form of communication if one does not have the opportunity to practice it throughout the day.

Availability of AAC across settings also promotes self-determination and well-being. Imagine if you could only speak for one or two hours each day, or only with certain specific people. This would quickly become frustrating!

Ability to enable open-ended communication

- Does the AAC method allow the person to use the entirety of the language they use most at home (e.g., English, Spanish, Mandarin, American Sign Language)?
- Can the AAC tool be used to form full sentences, greetings, questions, and directions? This is important even if the individual has not used full sentences in the past - it is impossible to learn to communicate in sentences if it is not possible using the available AAC method.
- Does the AAC tool allow the person to use words and phrases other than those that have been "pre-programmed" or added to the menu of available options? Does it allow the person to add words and phrases to the "menu"?

Equipment features

When choosing physical equipment - such as a speech-generating device, keyboard, or letterboard - it is also important to consider features such as:

- Weight: can the individual easily pick up and hold the equipment?
- Durability: is the equipment waterproof and shockproof? Can it easily be fixed or replaced? This may be particularly important if the individual frequently knocks, drops, or throws the equipment, or if the equipment must be used outdoors.
- Complexity: is the equipment easy to navigate and learn? Are letters and images big enough and clear enough for the individual to find and recognize? Are they organized in a predictable and

easy-to-understand way? Does the individual have to navigate multiple pages or screens in order to form the average sentence?

- Volume: In the case of a speech- or sound-generating device, it is important to consider volume. Can volume be varied so that the person can be heard in both quiet and noisy environments?
- Other technical features: in the case of high-tech equipment, you may want to consider features such as battery life and commercial availability. Technology with a long battery life or with replaceable batteries will be more likely to last throughout an entire day. Technology that is easily commercially available may be easier to replace or fix if it breaks.

> **“High-tech” equipment is not always better.** "High-tech" equipment can be heavy, fragile, or complicated. Low-tech solutions, such as letter-boards, may be more portable, durable, and easier to learn. Sometimes it may make sense to offer both high-tech and low-tech equipment and enable the individual to choose which one makes the most sense in any given situation.

Addressing Supporter Influence

Whenever an individual needs considerable support to communicate, the influence of a supporter may be a concern. The possibility of supporter influence is not restricted to only certain kinds of communication supports, nor does it mean that all communication using that support is inauthentic. It is important to keep in mind that people with developmental disabilities who do not use communication supports may be influenced by the people with whom they communicate - especially if they perceive those communication partners as authority figures or if they have been subjected to compliance-focused interventions.

Quality communication supports will acknowledge the possibility of conscious or unconscious supporter influence while also taking meaningful steps to minimize its likelihood.

Here are some traits of a **good** communication support provider:

- The supporter is committed to helping the individual increase his or her ability to communicate independently.
- The supporter does not contradict the individual.
- The supporter encourages others, such as parents and teachers, to learn the communication method as well.
- The supporter does not insist that the communication method he or she uses is the only accepted method.

Here are some signs of a **bad** communication support provider:

- The provider claims to be irreplaceable or tries to remain irreplaceable. For example:
    - In sessions with the supporter, the person receiving support makes hyperbolic statements about the supporter's importance, which are not repeated in communication with others.

- The supporter undermines or discredits the individual's attempts to communicate using other methods, insisting that only communications using the supporter's method are "valid."
- The supporter does not encourage others to learn the same method.
- The provider shows inappropriate emotional boundaries.
- The individual seems to have a different set of vocabulary words with the supporter than with family members.
- During open-ended communication, the supporter appears to be prompting the student by pointing to symbols or letters, or by "correcting" answers.

4: Sources of Communication Supports

Depending on age, an individual may be eligible for a variety of programs that may pay for communication-related services and supports. To avoid duplication of services or unnecessary expenses, many programs only pay for services and supports if the beneficiary cannot get them from other programs. As a result, it can help to follow a particular order when seeking access to services. This fact sheet describes the order of preference when seeking reimbursement for communication-related supports.

Fact Sheet: Order of Preference when Seeking Reimbursement

Children under Age 3

1. Private health insurance
2. Medi-Cal EPSDT Program
3. IDEA Part C (Regional Center)
4. Regional Center

People Age 3-21

1. IDEA Part B
2. Private health insurance
3. Medi-Cal EPSDT Program
4. Vocational Rehabilitation
5. Regional Center

People over Age 21

1. Private health insurance
2. Medi-Cal for Adults
3. Vocational Rehabilitation
4. Regional Center

The Americans with Disabilities Act may also require other entities, such as public programs or doctors' offices, to pay for communication supports while the individual is using a service, working as an employee, or participating in a particular program. There is no age limit on use of the ADA.

Medi-Cal EPSDT Program

California's Medicaid program, Medi-Cal, is a source of health coverage for over 13 million Californians, including about 5.6 million people under age 21.[1] People under age 21 may be enrolled in Medicaid because:

- They are children in families with incomes less than 266% of the federal poverty level;
- They are eligible for Supplemental Security Income (SSI);
- They are adults earning less than 138% of the federal poverty level;
- They are people with disabilities who are eligible through Medi-Cal's "Aged, Blind or Disabled" program or through Medi-Cal's workers with disabilities program.

Some people under age 21 may also be enrolled in Medicaid through other programs, such as the program for low-income pregnant individuals.

Medi-Cal beneficiaries under age 21 are entitled to special protections under federal Medicaid law. The law requires that Medi-Cal cover all medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. These services can include:

- Diagnostic assessments
- Communication assessments
- Occupational, physical, and speech-language therapies
- Assistive communication devices and training in use of these devices
- Other intensive communication interventions

Medi-Cal must cover these services for people under 21 whenever they are medically necessary, even if they aren't included in the official list of services covered by Medi-Cal (also known as the State Plan). Medi-Cal beneficiaries under age 21 are entitled to these services whether they're enrolled in "traditional" Medi-Cal or one of Medi-Cal's managed care programs.

For more information on EPSDT services that may be required for people with developmental disabilities, see recent guidance from the Centers for Medicare and Medicaid Services (CMS) on the EPSDT rights of people on the autism spectrum. [2] You may also want to refer to California Department of Health Care Services' All-Plan Letters describing EPSDT requirements in general and required behavioral health treatment (BHT) services for people on the autism spectrum (note that many communication-related services for people on the autism spectrum will not count as Behavioral Health Treatment but may still be covered by EPSDT in general).[3]

References

[1] Research and Analytic Studies Division, February 2017. Medi-Cal Monthly Enrollment Fast Facts, October 2016. California Department of Health Care Services. Available at: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_October_16_ADA.pdf. Accessed 1/12/2018.

[2] Centers for Medicaid and Medicare Services, July 2014. Clarification of Medicaid Coverage of Services for Children with Autism. Department of Health and Human Services. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf. Accessed 1/12/2018.

[3] Department of Health Care Services, September 2014. Interim policy for the provision of behavioral health treatment coverage for children diagnosed with autism spectrum disorder. State of California Health and Human Services Agency. Available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-011.pdf. Accessed 1/12/2018.

How to Access Services Using EPSDT

To request services through EPSDT, go through the regular procedure for requesting coverage for health care services through your Medi-Cal program. This may vary depending on whether the beneficiary is enrolled in traditional Medi-Cal or one of Medi-Cal's managed care programs.

If the plan responds that the service is not covered, you can file an "internal appeal." The process for filing the appeal should be described in the notice that the claim was denied. Make sure to:

- Include a letter from a doctor prescribing the screening or service, and explaining why the screening or service is medically necessary
- Note in the appeal that the service is covered by EPSDT

If the request is still denied, beneficiaries can ask for a Medi-Cal Fair Hearing.[1] For more information on how to file a hearing request, read the California DHCS web site.[2] Hearing requests can be made over the phone at 1-800-952-5253 (Voice) or 1-800-952-8349 (TDD). People can also request a hearing online.[3]

If a managed care plan cuts off services that the beneficiary was already getting, the beneficiary has special rights.[4] The plan must send the beneficiary a termination notice in advance. When the beneficiary gets this notice, they can file for a Medi-Cal Fair Hearing (see above) to appeal the decision to cut off the services. While the hearing is pending, the beneficiary can ask for "aid paid pending" - which means that the beneficiary can continue receiving the service until the appeal is decided.

References

[1] California Department of Health Care Services, (n.d.). Medi-Cal Fair Hearing. Available at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx. Accessed 01/18/2018.

[2] California Department of Social Services, (n.d.). State Hearing Requests. Available at: http://www.cdss.ca.gov/Hearing-Requests. Accessed on 01/18/2018.

[3] California Department of Social Services, (n.d.). Your Hearing Rights. Available at: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx. Accessed on 01/18/2018.

[4] California Department of Health Care Services, (n.d.). Continuity of Care and Managed Care – Frequently Asked Questions. Available at: http://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx. Accessed 01/18/2018.

Special Note on Assistive Communication (AAC) Devices. Medi-Cal covers many AAC devices as durable medical equipment. Disability Rights California has published a resource for beneficiaries on the process of requesting authorization for these devices.[1] As Disability Rights California notes in its resource, requests often require extensive documentation. These documents are described in the Medi-Cal Durable Medical Equipment and Medical Supplies manual. Because the documentation requirements are extremely complicated, providers, such as the AAC vendor or speech-language therapist, typically fill out these requests.

Medi-Cal will only cover the lowest-cost item that will serve the beneficiary's needs. If you need a very specific device, it is important to provide as much documentation of this need as possible and explain why lower-cost items will not adequately meet the beneficiary's needs.

References

[1] Disability Rights California, February 2016. Obtaining Assistive Technology through Medi-Cal. Available at: http://www.disabilityrightsca.org/pubs/558301.pdf. Accessed 01/18/2018.

Multi-use devices

Some AAC devices, such as iPads, Android tablets, software, and Bluetooth keyboards may not necessarily be covered. This is because Medi-Cal is only required to pay for speech-generating devices that are not generally useful to people without disabilities or other medical conditions. Since people without disabilities can use a tablet or Bluetooth keyboard, these may not automatically be covered.

You can still request coverage for these devices, however, especially if the beneficiary is enrolled in a Medi-Cal managed care program. To request coverage, submit a request for an AAC device that describes all the functions that the device must perform. You can then note that a device like a tablet can perform all of these functions at significantly less cost than the cheapest disability-specific device.

Timely Access to Care

Medi-Cal managed care companies may require beneficiaries to get services only through a list of in-network providers. This can cause problems if the in-network providers are overloaded and have long wait times for appointments.

California's Timely Access Law protects people enrolled in Medi-Cal. Under the law,

- Non-"urgent” specialist visits must generally be provided within 15 business days (about three work-weeks) of a request for an appointment;
- The managed care provider must make "pre-approval" decisions in time to schedule the appointment within 15 business days of the pre-approval request;

- Phone calls to the plan's customer service phone number during normal business hours should be answered by a staff member within 10 minutes;
- Urgent phone calls to the plan's customer service number should be answered, or someone must call you back, within 30 minutes. Urgent calls must be answered 24 hours a day, 7 days a week.

There may be exceptions when a doctor puts a note in the medical record that waiting longer than 15 business days would not harm the beneficiary's health. That means that it is important to make clear that, with communication services and assessments, every day counts. Many people with communication challenges have already waited a very long time before getting an assessment or receiving services. Because it can take a long time to develop communication skills even after the assessment, delays in getting an assessment can result in serious consequences for people's health care and quality of life. Moreover, even one day without access to effective communication supports can be frustrating or dangerous.

For more information on the Timely Access law, see the California DHCS web site.[1]

References

[1] California Department of Managed Health Care, (n.d.). Timely Access to Care. Available at: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx#.WOPeLPnytPZ. Accessed 01/18/2018.

More Resources

- Disability Rights California, Extra Services for Children and Youth under the Medi-Cal EPSDT Program: http://www.disabilityrightsca.org/pubs/552601.pdf

- Disability Rights California: Obtaining Assistive Technology through Medi-Cal: http://www.disabilityrightsca.org/pubs/558301.pdf

- Autistic Self Advocacy Network Guide to Medicaid Coverage for Autism Services: http://autisticadvocacy.org/wp-content/uploads/2015/07/Health-Insurance-and-Medicaid-Coverage-for-Autism-Services-A-Guide-for-Individuals-and-Families-7-9-15.pdf

Private Health Insurance

Some communication interventions and supports are available through private health insurance. Often, public service providers like Regional Centers will only pay for services that are not covered by private health insurance, Medicare, or Medi-Cal.

There are complicated laws governing what private health insurance must cover. For example:

- **The Affordable Care Act** requires that many health plans cover Essential Health Benefits, or EHB. Essential Health Benefits include habilitative services such as physical, occupational, or speech-language therapy.

- **California's Autism Insurance Law** requires private health plans to cover "behavioral health treatment" for people diagnosed with autism or autism spectrum disorder. This can include certain communication-related interventions, as long as they are evidence-based and designed to “develop or restore” a person's functional abilities (including communication).
- **California's Mental Health Parity Law** requires private health plans to cover all medically necessary interventions for "serious mental illness." Although developmental disabilities aren't often considered serious mental illness, the Mental Health Parity Law explicitly includes autism and pervasive developmental disability. Federal Mental Health Parity Law has similar requirements.
- A federal law called the **Employee Retirement Income Security Act of 1974** (ERISA) requires certain private health plans to make coverage decisions in a way that is not "arbitrary and capricious." It also requires the plans to provide a process for appealing a decision not to cover a service.
- **California's Timely Access to Care Law** requires managed care plans to make sure people can get health care appointments in a timely manner. This is the same law that protects timely access to care for people enrolled in Medi-Cal managed care. For more information on the Timely Access to Care law, please see our guide to Medi-Cal at the beginning of this chapter.

How to Access Services through Insurance

1. Review the terms of your health coverage plan.

- Is the type of service or equipment (e.g., speech-language therapy, speech-generating device) covered by the plan?
- Are there co-payment or cost-sharing requirements?
- Do you need pre-authorization? What kinds of documentation do you need to submit in order to get pre-authorization?
- Are there limits on how much you can use the service? Can you get an exception to those limits based on medical necessity?

  Note: Plans covered by the Affordable Care Act can’t impose annual cost limits on most covered services. They can, however, sometimes limit the number of hours or visits they will cover.

- Do you need to use someone in the plan's network?
- Does the plan only cover the service when it is provided by people with a certain kind of license or certification?
- If you are unsure, try calling the customer service number on your health insurance card and ask to speak with a plan representative.

Note on AAC Equipment. Not all private health plans include AAC or other durable medical equipment under the terms of the plan. Even when it is covered, the terms of the plan may only cover specialized equipment and not devices that can be used by non-disabled people, such as tablets or keyboards. However, you may still be able to convince the plan to cover this equipment – especially if you can argue that the equipment is cheaper than services you'd otherwise need. Try calling your customer service line and asking if there is a process for approving these kinds of expenses.

2. If you want to work with a specific provider, check with the provider.

- Do they take your insurance?
- Does the provider you want to use meet your plan's licensing or certification requirements?
- Are they familiar with which services are and aren't covered by your insurance?

3. Follow the insurance plan's process, if any, for pre-approving the service.

- Gather the documents you need. This may include:
  - A letter from the beneficiary's doctor explaining the need for the assessment, service, or technology
  - Other relevant medical or educational records, including all relevant assessments
- Write a letter requesting pre-approval. This guide includes a sample letter for you to use (see Chapter 5.)
- Send the letter requesting pre-approval, along with the documentation you gathered.

Keep in mind that California's Timely Access Law typically requires managed care plans to respond to your letter requesting pre-approval in time to schedule an appointment within 15 business days of the request. That is about three work-weeks. For more information on the Timely Access to Care law, please see our guide to Medi-Cal at the beginning of this chapter.

Prior Authorization. You may want to request prior-authorization even when the insurance plan does not require it – especially if you are concerned that you would not be able to pay for the eservice out-of-pocket if the insurance plan decides not to reimburse you.

4. If necessary, file an appeal.

If you do not get pre-approval for the assessment or service, you can appeal that decision. The process of appealing the decision may vary depending on what kind of plan you have. To file an appeal, you must:

- Read the letter denying pre-approval. The letter must include a reason that the claim was denied.
- Collect documents responding to the reason the claim was denied. This can include:

  - Medical necessity. Collect letters from doctors and other providers explaining why the communication service is medically necessary. If the beneficiary has received the service before, include information on any progress that the beneficiary has made and need for further services.
  - Lack of evidence base. Ask the service provider to write a letter explaining why the service is evidence-based. You may also want to include copies of medical journal articles discussing the service.
  - The service is "educational." Attach a copy of the beneficiary's IEP, if any. Explain that the service you're requesting is different from the services described in the IEP.

For more information on information to include in response to these reasons for denial, check out the Autistic Self Advocacy Network's resource on accessing health coverage through private insurance.[1]

- File an internal appeal. You should follow the process described in the letter denying pre-approval. See Chapter 5 of this toolkit for a sample appeal letter.
- If this appeal is denied, you may also file a request for Independent Medical Review (IMR) with California's Department of Managed Healthcare (DMHC) or Department of Insurance (DI). For more information on how to do this, see Disability Rights California's resource on Private Insurance Appeals.[2]

References

[1] Autistic Self Advocacy Network, (n.d.). Private Health Coverage for Autism Services: A Guide for Individuals and Families. Available at: http://autisticadvocacy.org/wp-content/uploads/2016/11/Private-Health-Coverage-for-Autism-Services-A-Guide-for-Individuals-and-Families-1.pdf. Accessed 01/18/2018.

[2] Disability Rights California, September 2012. Private Insurance Appeals Including Independent Medical Review (IMR) for Health Plans under the Authority of the California Department of Managed Health Care (DMHC) of Department of Insurance (DI). Available at: http://www.disabilityrightsca.org/pubs/F07201.pdf. Accessed 01/18/2018.

Legal Help

If you have exhausted the appeals process or need extra help to navigate it, you may wish to consult an attorney. Organizations that may help include:

- Disability Rights California: http://www.disabilityrightsca.org/
- Autism Deserves Equal Coverage: http://www.autismcoverage.org/
- Mental Health and Autism Insurance Project: https://mhautism.org/
- Your local Office of Clients’ Rights Advocacy: http://www.disabilityrightsca.org/about/OCRA.htm

More Resources

- Easter Seals' State Autism Profile: California: http://www.easterseals.com/explore-resources/living-with-autism/profiles-california.html
- Disability Rights California Guide to Mental Health Parity under California and Federal Laws: http://www.disabilityrightsca.org/pubs/CM2401.pdf

IDEA Part B

The Individuals with Disabilities Education Act (IDEA) Part B requires schools to provide assessments and specialized instruction to people with disabilities ages 3 to 21.

Who is Eligible

To be covered by the IDEA Part B, a student must:

- Be between the ages of 3 and 21
- Have a disability that gives rise to a need for special education. Examples may include:
    - Autism
    - Speech/language impairment, including apraxia
    - Intellectual disability
    - Deafness
    - Orthopedic impairment
- Not have already graduated from high school

What is Covered

Schools must provide services that are necessary to enable a child to get a Free Appropriate Public Education (FAPE). These can include:

- Disability-related evaluations and screenings, including communication assessments for students with communication-related disabilities
- Special education services, which may include specialized literacy and language instruction
- Related services, such as:
    - Speech-language therapy
    - Physical therapy
    - Occupational therapy
    - Assistive communication supports, such as AAC, and training for the student and family on how to use it

How Do You Request Services?

Age 3 through Kindergarten

Children aged 3 through Kindergarten-aged can be connected to services through one of two paths:

1. If the child was already receiving services under IDEA Part C, the service coordinator should help develop a transition plan to help connect the child to IDEA Part B services once the child reaches age 3.

2. If the child has not already been receiving services through the IDEA, the family should write a letter to the principal or special education coordinator for the local school district. The school must then develop a plan to evaluate the child and determine if the child is eligible for special education services.

For more information, see Disability Rights California's Information on Preschool Education Services in its Special Education Rights and Responsibilities (SERR) manual.[1, 2] You may also want to refer to the National Center for Learning Disabilities' Parent Advocacy Brief on Preschool Services under the IDEA.[3]

References

[1] Disability Rights California, (n.d.). Special Education Rights and Responsibilities: Information on Preschool Education Services. Available at: http://www.disabilityrightsca.org/pubs/504001Ch13.pdf. Accessed 01/18/2018.

[2] Disability Rights California, September 2011. Special Education rights and Responsibilities (SERR) manual. Available at: http://www.disabilityrightsca.org/pubs/PublicationsSERREnglish.htm. Accessed 01/18/2018.

[3] National Center for Learning Disabilities, (n.d.). Parent Advocacy Brief: Preschool Services under the IDEA. Available at: https://dredf.org/wp-content/uploads/2014/04/preschool_brief.pdf. Accessed 01/18/2018.

Kindergarten through age 21

Public schools have an affirmative obligation to identify students who may be in need of special education services. Students may be referred for special education:

- Because a teacher or other school employee suspects that the student has a disability
- Because or student's parents or the student (if over 18) tell the school that the child has a disability
- Because the parent (or the student, if over 18) asks the school or a staff member for an evaluation for special education services (this request can be oral or in writing)
- Because some other service provider (such as a Regional Center, department of child services, foster parent, or social worker) tells the school or a staff member that the child has or may have a disability (however, the school cannot conduct an assessment or provide services without the parent or guardian's consent).

For more information, see Disability Rights California's Information on Evaluations/Assessments in its Special Education Rights and Responsibilities (SERR) manual.[1]

References

[1] Disability Rights California, (n.d.). Special Education Rights and Responsibilities: Information on Evaluations/Assessments. Available at: http://www.disabilityrightsca.org/pubs/504001Ch02.pdf. Accessed 01/18/2018.

Assessments

Once the student has requested or been referred for special education, the school district must complete an assessment to decide if the student is eligible for special education and related services. This may include a communication assessment. If the school district does not have staff capable of performing an adequate communication assessment, it must pay for a private assessment.

Developing a Service Plan

If the school district finds the child eligible for special education and related services, it must hold a meeting to develop an Individualized Education Program (IEP). The IEP team must include anyone who has information relevant to the student's education, including the child's parents, teachers, service providers, and others who know the student well. If the student is old enough to participate in the planning process, the child must also be given a chance to participate. If the student is over age 18, he or she may have the right to decide whether or not to continue to include his or her parents in the IEP planning process.

The service plan must identify the student's educational goals, including goals for developing communication-related skills. The plan must also identify the special education services and related services that the school district will provide to help the student reach those goals. These services may include:

- Specialized literacy and language instruction
- Speech-language therapy
- Physical therapy
- Occupational therapy
- Assistive communication supports, such as AAC, and training for the student and family on how to use it
- Transition planning and services to help the student live independently after graduating or aging out of the public school system.

Advocating for Communication Supports

The school district *must* provide all the services that are necessary to provide the student with a Free, Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE). Wherever possible, this means the student must make progress in the general curriculum and be included to the maximum extent possible in the general classroom. FAPE also includes development of appropriate independent living and social skills.

Communication supports are necessary for both of these goals. Students cannot make progress in the general curriculum without the ability to understand lessons, communicate what they know, and ask questions. They cannot become independent without the ability to communicate their needs, desires, and decisions. They cannot develop social skills without the ability to communicate with their classmates.

Moreover, students often are excluded from the mainstream classroom when they are unable to communicate effectively. Instead, they are often segregated to special education classrooms. Families should know that an IEP that does not include necessary communication supports or that sets only minimal communication goals is probably not an adequate IEP.

Students also may be entitled to communication supports outside the classroom and outside school. For example, a student who is learning to communicate using a speech-generating device will not make much progress if the speech-generating device is only available during the school day or only available during certain classes. The school may be required to let the student take the speech-generating device home. The school may also be required to train the student's parents in how to support the student's use of the device outside the classroom.

Due Process Hearings

If the school does not conduct an assessment or does not agree to provide services that the family (or student, if age 18 or over) believe are necessary, the student or family may request a due process hearing. At the hearing, the family has the opportunity to present evidence and explain to a hearing officer why the assessment or services are necessary to provide the student with a Free Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE).

Section 504 of the Rehabilitation Act

Students also may be entitled to communication supports in school under a law called the Rehabilitation Act. Section 504 of the Rehabilitation Act gives students the right to effective communication supports in schools and other public programs. These supports may include:

- Interpreters
- Access to AAC
- Access to communication aides trained in the student's preferred method of communication

Section 504 gives students some rights in addition to the IDEA. For example, Section 504 requires schools to give priority to the student's preferred method of communication. If, for example, the student is already proficient at a particular AAC method, the school usually must provide access to that specific AAC method and not attempt to substitute another method that the school prefers. If the school wants to propose another method, it must prove that the other method is equally effective *for that student*.

Section 504 of the Rehabilitation Act does not cover instruction in how to use communication supports. If, for example, the student needs to be taught how to use an AAC device, that may be more appropriately addressed through the IDEA.

Section 504 can sometimes be addressed in the same meeting in which the school develops the IEP. In other cases, the family must make a request to the school's "Section 504 Coordinator." The school administrator must provide families with information about how to contact the school's Section 504 Coordinator.

More Resources

- Disability Rights California, Obtaining Assistive Technology through Your Child’s School: http://www.disabilityrightsca.org/pubs/557701.pdf
- National Center for Learning Disabilities, IDEA Parent Guide: https://www.ncld.org/wp-content/uploads/2014/11/IDEA-Parent-Guide1.pdf

IDEA Part C

IDEA Part C is a program that covers early intervention services for children with disabilities from birth through age 2. A child does not have to be enrolled in school to participate in IDEA Part C.

Who Provides the Service?

In California, Regional Centers are responsible for providing IDEA Part C services to children with developmental disabilities. School districts are responsible for providing services to children whose disabilities are solely due to vision, hearing, or orthopedic impairments.

Regional Centers are funders of last resort. This means that even if a child is eligible for IDEA Part C, the Regional Center may require the family to obtain certain services through their private insurance plan or Medi-Cal. Even if a child can get services through insurance or Medicaid, however, the Regional Center will still pay for the initial assessment and will provide services while the family is waiting for insurance or Medi-Cal to approve the service.

Who is Eligible?

Children under age three are eligible for IDEA Part C services if they have a developmental delay affecting communication development. They may also be eligible if they have a developmental disability affecting cognitive development; physical and motor development, including vision and hearing; social or emotional development; or adaptive development.

Because it may be difficult to diagnose children at a young age, the delay does not need to be caused by a known disability. Instead, a qualified professional only needs to find that there is a "significant difference" between the child's current level of functioning and the level of development expected for children of the same age. Delays are significant if:

- The child is under age 2 and there is a **33%** difference between the child's abilities in **one or more domain**, and the abilities expected for children their age;
- The child is over age 2 and there is a **50%** difference between the child's abilities **in one domain,** and that expected for children of the same age; or
- The child is over age 2 and there is a **33%** difference between the child's abilities **in two or more domains**, and that expected for children the same age.

Children who are diagnosed as being "at risk" for developmental delays may also be eligible, as long as their underlying condition has a high probability of leading to a developmental disability in the future. However, funding for children in this category is limited and it is possible that not every child in this group will receive services.

What is Covered

IDEA Part C services can include:

- Assessments and screenings
- Speech-language therapy
- Occupational therapy
- Physical therapy
- Service coordination
- Assistive technology, including AAC and training on how to use AAC
- Family counseling and training

Services under IDEA Part C must be provided in the child's "natural environment," such as the home. Sometimes the services will be provided in a group setting so that children can learn to interact with peers.

How to Access Services

To access services through IDEA Part C, the Regional Center must receive a referral for services by the parent, doctor, or some other service provider (such as a day care program, child welfare program, or other health or social services provider). The referral can be made either over the telephone to the local Regional Center or through a letter. The referral must:

1. Describe the child's needs; and
2. Ask for early intervention services.

Once it has received a referral and the parents have consented to services, the Regional Center must do all of the following things within **45 days**:

1. Provide a timely and comprehensive evaluation - including a communication assessment if needed.
2. Make an eligibility determination. The determination should take into account not only the assessment but also other health records and input from people who know the child well.
3. If the child is eligible, the Regional Center must complete an assessment for service planning that takes into account the child's needs and strengths, as well as the family's overall situation, priorities, and resources. It must identify early intervention services to address the child's needs.

4. If the child is eligible, the Regional Center must also develop an Individualized Family Service Plan (IFSP). This plan must be developed by an interdisciplinary team that includes the parents.

The IFSP for a child with communication delays must include:

- A description of the child's current communication abilities.
- A description of the child's communication goals, and a statement of the services that the child will receive to achieve these goals.
- Concrete dates on which the services will begin (children with IFSPs cannot be placed on waiting lists).
- A description of who will be providing the services.
- A person who will be coordinating the services.
- A transition plan to ensure the child continues to receive appropriate services from other providers (such as the school district) after reaching age 3.

Enforcing Rights to IDEA Part C Services

Due Process Hearings

If a family disagrees with the Regional Center's IFSP proposal, it may request a "due process" hearing. At the hearing, the family can explain why it believes that the child needs services other than those offered by the Regional Center. If the Regional Center is proposing to stop providing a service that it has provided to the child in the past, the child's family can invoke their right to "stay put," or continue receiving services, while the hearing is pending.

Hearing requests should be sent to:

Office of Administrative Hearings
2349 Gateway Oaks Drive, Ste. 200
Sacramento, CA 95833
Facsimile: 916-376-6318
Attn: Early Start

The hearing request must include:

- The complainant's name
- The name of the child
- The complainant's address and telephone number
- A description of the child's disability
- A description of the services the family is requesting and an explanation of why the services are necessary
- A description of any steps the family has already taken to resolve the issue.

You can contact the Office of Administrative Hearings at (916) 263-0654.

Complaints

If the family believes that the Regional Center has failed to provide the services in the IFSP or has failed to follow the required procedures, they may file a complaint. The complaint should be addressed to:

California Department of Developmental Services
Office of Human Rights and Advocacy Services
Attn: Early Start Complaint Unit
1600 Ninth Street, Room 240, M.S.- 215
Sacramento, CA 95814

The complaint must include:

- The complainant's name
- The name of the child
- The complainant's address and telephone number
- A description of the facts underlying the complaint
- A description of any steps the complainant has already taken to resolve the issue.

If the family already has a service coordinator, the service coordinator must help with writing and filing the complaint.

Other Resources

To learn more about IDEA Part C Services, please see:

- Disability Rights California's Information on Early Intervention Services: http://www.disabilityrightsca.org/pubs/504001Ch12.pdf
- Disability Rights California, Special Education Rights and Responsibilities (SERR) manual: http://www.disabilityrightsca.org/pubs/PublicationsSERREnglish.htm
- The Special Education Guide, The Who, What, and Why of an Individual Family Services Plan (IFSP): https://www.specialeducationguide.com/early-intervention/the-who-what-why-of-an-individual-family-services-plan-ifsp/

Regional Centers and the Lanterman Act

In California, the Lanterman Act entitles people with developmental disabilities to a wide range of services and supports. This can include communication supports. These services are coordinated by a system of Regional Centers, which may also fund some of these supports directly.

Who is Entitled to Services through the Lanterman Act?

Anyone with a developmental disability is covered by the Lanterman Act, regardless of age. A developmental disability covered under this Act is a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. A substantial disability means significant functional limitations in three or more of the following areas of major life activity:

- Self–care,
- Receptive and expressive language,
- Learning,
- Mobility,
- Self–direction,
- Capacity for independent living, and
- Economic self–sufficiency.

What Services are Available under the Lanterman Act?

Regional Centers also fund many services. These can include:

- Assessment and diagnosis
- Counseling
- Individualized planning supports
- Directly providing supports and services that are not covered through other sources
- Independent living programs that help support adults to live in their own homes
- Self-determination programs, which give people a budget that they can use to purchase the services and supports they need to live independently and exercise greater autonomy

Regional Centers also help coordinate and access services that are funded through other programs. For example, they may:

- Help people understand which resources are available in the community
- Help people apply for services in the community, such as Vocational Rehabilitation and Medicaid services
- Connect people to programs that protect and advocate for individuals' legal rights

Regional Centers specifically must either fund or help people access certain supports that help with communication, self-determination, and independent living. These can include:

- Assistive technology and training on how to use it[1]
- Personal assistants to help an individual communicate or use a communication device
- Interventions aimed at improving communication, such as speech-language therapy and occupational therapy

- Service coordination services that help ensure continuity of access to communication devices and supports

References

[1] Disability Rights California, October 2015. Funding Assistive Technology through the Regional Center. Available at: http://www.disabilityrightsca.org/pubs/557901.pdf. Accessed 01/18/2018.

Payor of Last Resort

Regional Centers are payors of last resort. This means that if a service is available through certain state or federal programs - such as Medicaid, the public school system, or private insurance - the Regional Center is not allowed to pay for it. Regional Centers cannot directly pay for services that are available through:

- Medi-Cal (Medicaid)
- Medicare
- The Civilian Health and Medical Program for Uniform Services
- In-Home Support Services
- California Children's Services
- private insurance, or
- a health care service plan

Cal. Welfare and Institutions Code Section 4659.[1] Exceptions can be made when the person with a disability is under three years of age, when the individual is still in the process of applying for coverage of those services, or when these programs have issued a letter denying coverage for these services.

The Regional Center is also required to investigate other sources of payment for services, even sources that are not on that list, but is allowed to pay for such services in the meantime. For example, Regional Centers may be required to investigate whether or not a service can be funded through the Vocational Rehabilitation program. However, the Regional Center can pay for a service that *could* be available through Vocational Rehabilitation. This is important because *both* Vocational Rehabilitation agencies and Regional Centers are supposedly payors of last resort. By allowing Regional Centers to pay for services that could also be available through Vocational Rehabilitation, the law allows Regional Centers to develop cooperative agreements with Vocational Rehabilitation that allow them to decide for themselves who will cover which costs. Otherwise, Regional Center clients may be stuck getting bounced between these agencies and not receive the services they need.

References

[1] FindLaw, (n.d.). California Code, Welfare and Institutions Code Section 4659. Available at: http://codes.findlaw.com/ca/welfare-and-institutions-code/wic-sect-4659.html. Accessed 01/18/2018.

How Does One Access Services under the Lanterman Act?

To get services through the Lanterman Act, a person must be evaluated and determined eligible by the Regional Center. Once the person is found eligible, the Regional Center will work with the individual to create an Individual Program Plan (IPP). The IPP will list the individual's needs and goals. It will also include a list of supports that the individual will receive, either directly through the Regional Center or through other programs. The Regional Center will help the individual go through the necessary steps to access supports in the IPP that are to be provided through other programs.

The IPP is developed through a team process. The team includes not only the Regional Center and the individual but also members of the individual's support network. Once the IPP is signed, the Regional Center cannot make significant changes without providing notice and an opportunity to object.

If an individual does not believe that the IPP provides adequate services, the individual can object to the IPP. Objecting to the IPP triggers a dispute resolution process that may result in a hearing. People may ask for assistance with the appeals process by contacting the Clients' Rights Advocate and Area Board. These offices can then appoint someone to help the individual with his or her appeal.

The appeals process is similar to the process of appealing Medicaid or health insurance decisions in that the person filing an appeal may be required to provide documentation and explanation of the need for the service he or she is seeking. However, it is also different from the process of appealing a Medicaid or health insurance decision in that it may also require the individual to testify in person before an Administrative Law Judge. People may even present witnesses at the hearing. If the person filing an appeal needs help testifying or will need a communication supporter present, it is important to make this request well in advance of the hearing. For more on the appeals process, read Disability Rights California's guide to the dispute resolution process.[1]

References

[1] Disability Rights California, (n.d.). Rights under the Lanterman Act: Disagreements with Regional Centers and Developmental Centers. Available at: http://www.disabilityrightsca.org/pubs/506301Ch12.pdf. Accessed 01/18/2018.

Americans with Disabilities Act

The Americans with Disabilities Act ("the ADA") is a federal law that protects the rights of people with disabilities. It protects against discrimination in employment, state-funded programs, and places of public accommodation such as stores, hospitals, and doctor's offices.

Another law, Section 504 of the Rehabilitation Act ("Section 504"), protects against discrimination in programs funded by the federal government - including any program funded by Medicaid. Although these laws apply to different programs, they have essentially the same requirements.

Who is Protected?

People with significant communication needs are generally considered people with disabilities for the purposes of the ADA and Section 504. That means that they are protected.

In some cases, people with disabilities may also have to show that they are "qualified individuals with disabilities." A "qualified individual" is someone who meets the requirements of a job or a program, either with or without reasonable accommodations. For example, some jobs can't be done without communication - but a person with a communication disability could still do the job with the right supports. That person would still be a "qualified individual" even if he or she could not do the job without communication supports.

What Kinds of Places are Covered?

The ADA has multiple sections, called titles. Each title covers a different kind of program.

- Title I covers employers. To be covered by the ADA, an employer must have 15 or more employees. States and local governments can also be covered under Title I when they're acting as an employer.
- Title II covers state and local government programs. These can include state hospitals, state universities, local police forces, and state Medicaid programs. They may also cover public transportation programs run by the state, city, or county.
- Title III covers places of public accommodation. These include:
    - Restaurants and other places serving food or drinks to the public
    - Hotels and similar places of lodging
    - Public gathering places like lecture halls and auditoriums
    - Public parks, playgrounds, zoos, and amusement parks
    - Stores and rental services
    - Services offered to the public, including pharmacies, doctors' offices, hospitals, lawyers, barber shops, and gas stations
    - Libraries, galleries, and museums
    - Social services establishments like day care centers, senior centers, adult day centers, shelters, and food banks
    - Recreational facilities such as gymnasiums, bowling alleys, or golf courses
    - Educational services, including places of higher education and vocational schools
    - Public transportation stations and stops

Again, Section 504 also covers programs that receive federal government funding. These can include:

- Any health facility that is reimbursed by Medicare or Medicaid
- Any place of higher education that serves students receiving federal financial aid
- Any federal government program, such as the Social Security Administration or Veterans' Hospitals

What Communication Supports are Available through the ADA and Section 504?

The ADA and Section 504 both protect against discrimination. Discrimination can mean *either*:

- Excluding someone based on a disability alone. For example:
    - A store cannot refuse to serve someone who uses a communication support.
    - A school cannot reject a student simply because the student uses communication supports.
- Failing to provide a reasonable accommodation. For example:
    - A testing service (such as the SAT) must make reasonable modifications to its policies so that a student can use necessary communication technology or supports. It may also have to provide the person with extra time in order to account for the extra time it takes to use certain forms of communication technology.
    - A doctor's office must allow a person to bring a communication supporter to an office appointment.
    - An employer must allow a person to use an AAC device at work.

Sometimes, the ADA and Section 504 will require provision of *auxiliary aids and services* to people with disabilities who need them, including people who need them in order to communicate effectively. These include:

- Sign language interpreters
- Note takers
- Captioning
- Information provided in writing
- Speech-to-speech interpreters or transliterators

In some cases, the ADA and Section 504 may even entitle a person to temporary use of an AAC device. For example, if a person with a communication disability is hospitalized and does not have his or her own AAC device, the hospital may be required to provide an AAC device for the person to use during the course of the hospital stay.

An organization's responsibility to provide these aids and services will depend on:

- The nature of communication. For example, a restaurant or store may be able to communicate with a customer through pointing or writing things down. In that case, the store will not have to provide something more complicated, like an assistive communication device or a sign-language interpreter. However, a hospital may be required to provide a sign-language interpreter.
- The type of organization or service. Titles II and III of the ADA, as well as Section 504, include specific requirements that auxiliary aids and services be provided to ensure effective communication.[1] These services must prioritize the person's preferred form of communication.
    - Employers may sometimes also be required to provide similar services as a reasonable accommodation, but they have the ability to go through an interactive process to decide

on which accommodation will be provided. This means that they may not be required to defer as much to the person's preferred form of communication.

- The financial impact of providing effective communication supports. Sometimes, an entity covered by the ADA may object that providing effective communication supports or accommodations is too expensive. The fact that services cost money, however, is not itself enough to exempt the entity from providing the communication support. Whether or not it is an undue financial burden should be decided in light of *all* the resources available to the organization. Therefore, a large hospital with a multi-million-dollar operating budget may be required to provide interpreter services even though the cost may seem high in comparison to the amount of money they are receiving to care for that particular patient.

References

[1] U.S. Department of Justice, Civil Rights Division, Disability Rights Section, (n.d.). ADA Requirements: Effective Communication. Available at https://www.ada.gov/effective-comm.htm. Accessed 01/18/2018.

How Do I Get Communication Supports through the ADA or Section 504?

An entity covered by the ADA or Section 504 needs to know that an accommodation is necessary before it is obligated to provide it.

In some cases, it will be obvious that a person has a disability, that the person cannot communicate without support, and that the person needs a particular communication. For example, if an individual arrives at a hospital with a communication device and a supporter who is helping him or her use it, the hospital is on notice that that individual will need to be allowed to use the device and to stay with the supporter.

In other cases, the individual may need to actively request an accommodation. To request an accommodation, an individual must make it clear that he or she has a disability *and* needs a particular accommodation as a result of that disability. In these cases, it is critical that the word "disability" be used in the request; simply saying, "I'd like this person here because she helps me understand things" may not be enough to provide notice that a support person is necessary under the ADA.

Sometimes an individual may be required to provide advance notice of an accommodation need. For example, when making a doctor's appointment, it may be necessary to tell the doctor's office about the need for an interpreter *at the time that the appointment is made*. And in some contexts - for example, employment or requests for accommodations in educational or testing contexts - it may be necessary to not only provide advance notice but also provide documentation of the need for the accommodation.

Whether or not advance notice or documentation is required may depend on the nature of the service (i.e., a "walk-in" service versus an ongoing service or appointment) and the difficulty of providing the accommodation (i.e., arranging for an interpreter or simply allowing a person to bring a communication supporter to an appointment). When possible, always ask service providers in advance what their accommodation policies are.

Additional Resources

- To find useful scripts for requesting communication supports in the health-care context, visit the Academic Autistic Spectrum Partnership in Research and Education (AASPIRE) website and click on "Personalized Accommodations Report.": https://autismandhealth.org/.
- For more information on effective communication in schools, see the joint guidance from the Department of Justice and Department of Education: https://www.ada.gov/doe_doj_eff_comm/doe_doj_eff_comm_faqs.htm
- For more on State and Local Governments' obligations, see the Department of Justice, ADA Best Practices Toolkit for State and Local Government: https://www.ada.gov/pcatoolkit/chap3toolkit.htm
- To ask questions about the ADA and its requirements, try contacting the Department of Justice ADA Information Line: https://www.ada.gov/taprog.htm

Medi-Cal for Adults

California's Medicaid program, Medi-Cal, is a source of health coverage for over 13 million Californians, including almost 8 million people over age 21.[1] People over age 21 may be enrolled in Medicaid because:

- They are adults earning less than 138% of the federal poverty level;
- They are eligible for Supplemental Security Income (SSI);
- They are former foster youth under age 26;
- They are low-income pregnant women or parents of children; or
- They are people with disabilities who are eligible through Medi-Cal's "Aged, Blind or Disabled" program or through Medi-Cal's workers with disabilities program.

Medi-Cal beneficiaries over age 21 are no longer eligible for the full complement of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, but may still be eligible for coverage of a range of communication-related services. These services can include:

- Diagnostic assessments
- Communication assessments
- Occupational, physical, and speech-language therapies
- Assistive communication devices and training in use of these devices
- Other intensive communication interventions

How to Access Services through Medi-Cal for Adults

The process for requesting services through Medi-Cal will depend on the program in which you are enrolled, such as traditional Medi-Cal or one of Medi-Cal's managed care programs.

If the plan responds that the service is not covered, you can file an appeal. Make sure to include a letter from a doctor prescribing the screening or service, and explaining why the screening or service is medically necessary. Services that identify communication needs, improve communication skills, or otherwise support effective communication are likely to be medically necessary. For more information on what information you may want to include in the request, see the Autistic Self Advocacy Network Guide to Medicaid Coverage for Autism Services[2].

If your request is still denied, you can ask for a Medi-Cal Fair Hearing. For more information on how to file a hearing request, read the California DHCS web site.[1] Hearing requests can be made over the phone at 1-800-952-5253 (Voice) or 1-800-952-8349 (TDD). People can also request a hearing online[3].

If a managed care plan cuts off services that the beneficiary was already getting, the beneficiary may have special rights[4]. The plan must send the beneficiary a termination notice in advance. When the beneficiary gets this notice, they can file for a Medi-Cal Fair Hearing (see above) to appeal the decision to cut off the services. While the hearing is pending, the beneficiary can ask for "aid paid pending" - which means that the beneficiary can continue receiving the service until the appeal is decided.

> **Special Note on Assistive Communication (AAC) Devices.** Medi-Cal covers many AAC devices as durable medical equipment. Disability Rights California has published a resource for beneficiaries[5] on the process of requesting authorization for these devices. As Disability Rights California notes in its resource, requests often require extensive documentation. These documents are described in the Medi-Cal Durable Medical Equipment and Medical Supplies manual. Because the documentation requirements are extremely complicated, these requests are typically filled out by providers, such as the AAC vendor or speech-language therapist.
>
> Medi-Cal will only cover the lowest-cost item that will serve the beneficiary's needs. If you need a very specific device, it is important to provide as much documentation of this need as possible and explain why lower-cost items will not adequately meet the beneficiary's needs.

Multi-use Devices

Some AAC devices, such as iPads, Android tablets, software, and Bluetooth keyboards may not necessarily be covered. This is because Medi-Cal is only required to pay for speech-generating devices that are not generally useful to people without disabilities or other medical conditions. Since people without disabilities can use a tablet or Bluetooth keyboard, these may not automatically be covered.

You can still request coverage for these devices, however, especially if the beneficiary is enrolled in a Medi-Cal managed care program. To request coverage, submit a request for an AAC device that describes all the functions that the device must perform. You can then note that a device like a tablet can perform all of these functions at significantly less cost than the cheapest disability-specific device.

Timely Access to Care

Medi-Cal managed care companies may require beneficiaries to get services only through a list of in-network providers. This can cause problems if the in-network providers are overloaded and have long wait times for appointments.

California's Timely Access Law protects people enrolled in Medi-Cal. Under the law,

- Non-"urgent" specialist visits must generally be provided within 15 business days (about three work-weeks) of a request for an appointment;
- The managed care provider must make "pre-approval" decisions in time to schedule the appointment within 15 business days of the pre-approval request;
- Phone calls to the plan's customer service phone number during normal business hours should be answered by a staff member within 10 minutes;
- Urgent phone calls to the plan's customer service number should be answered, or someone must call you back, within 30 minutes. Urgent calls must be answered 24 hours a day, 7 days a week.

There may be exceptions when a doctor puts a note in the medical record that waiting longer than 15 business days would not harm the beneficiary's health. That means that it is important to make clear that, with communication services and assessments, every day counts. Many people with communication challenges have already waited a very long time before getting an assessment or receiving services. Because it can take a long time to develop communication skills even after the assessment, delays in getting an assessment can result in serious consequences for people’s health care and quality of life. Moreover, even one day without access to effective communication supports can be frustrating or dangerous.

For more information on the Timely Access law, see the California DHCS: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx#.WOPeLPnytPZ.

References

[1] Autistic Self Advocacy Network, Guide to Medicaid Coverage for Autism Services: http://autisticadvocacy.org/wp-content/uploads/2015/07/Health-Insurance-and-Medicaid-Coverage-for-Autism-Services-A-Guide-for-Individuals-and-Families-7-9-15.pdf

[2] Medi-Cal Fair Hearing: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

[3] Fair Hearing Request: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx#.WOPeLPnytPZ

[4] Medi-Cal Managed Care Beneficiaries: http://www.dhcs.ca.gov/services/Pages/ContinuityofCareFAQ.aspx

[5] Disability Rights California, Obtaining Assistive Technology through Medi-Cal: http://www.disabilityrightsca.org/pubs/558301.pdf

5. Sample Letters

Medi-Cal Appeal Letter

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

Re: [Name of Beneficiary], Member # [Member ID Number] Claim # [Claim Number]

To Whom It May Concern:

I am writing to request a Medi-Cal Fair Hearing for [Beneficiary]. **[Beneficiary]** is enrolled in [Medi-Cal Program or Managed Care Provider] in [County].

On [date], I received a letter denying [Beneficiary]'s request for coverage for [service] by **[name of provider]**. The reason for denial was listed as [reason listed for denial].

[Describe any previous efforts you may have made to appeal the decision internally.]

[Beneficiary] is under age 21 and is therefore entitled to these services through the EPSDT mandate. [Service] is medically necessary in order to ensure that [Beneficiary] can communicate effectively.

I am attaching a letter from [Beneficiary]'s [type of treatment provider], [name], who has determined that this intervention is evidence-based and medically necessary due to [describe specific needs of the beneficiary that will be addressed by the service]. The intervention will address these needs by [describe what is involved in the intervention].

[Beneficiary] is not already receiving this service through the IDEA. I am attaching a copy of [his/her] most recent IEP. [Add details, if necessary, explaining why the service is different from those described in the IEP - e.g., the beneficiary is working towards different goals at school than those that the requested service would work towards; the beneficiary is only receiving the service during school hours and needs access to the same service outside school hours, etc.]

[Add more detailed information if possible. If you are including other documents such as prior assessments, include a list of what you are sending here.]

If you need additional information, I can be reached at [telephone number and/or e-mail address].

Sincerely,

[Signature]

[Typed Name]

You can either address the letter to:

1. The county welfare department shown on the Notice of Action;
2. The California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430;
3. To the State Hearings Division at fax number (916) 651-5210 or (916) 651-2789; or
4. Request a Hearing Online: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

Medi-Cal Managed Care Cut-off Letter

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

Re: [Name of Beneficiary], Member # [Member ID Number] Claim # [Claim Number]

To Whom It May Concern:

I am writing to request a Medi-Cal Fair Hearing for [Beneficiary]. [Beneficiary] is enrolled in [Medi-Cal Program or Managed Care Provider] in [County]. In order to ensure continuity of care, I am requesting aid paid pending the resolution of the hearing.

On [date], I received a letter saying that [Beneficiary] will no longer receive coverage for [service] by [name of provider]. The reason for denial was listed as [reason listed for denial].

[Note whether the beneficiary changed Medi-Cal plans within the past 12 months. If so, note whether the beneficiary had received these services through his or her previous plan].

[Describe any previous efforts you may have made to appeal the decision internally.]

[Beneficiary] is under age 21 and is therefore entitled to these services through the EPSDT mandate. [Service] is medically necessary in order to ensure that [Beneficiary] can communicate effectively. [Beneficiary] has already benefited from this service by [describe benefit] and is continuing to make progress toward [goal]. It is critical that [Beneficiary] continue to receive the service in order to continue making progress toward [goal], avoid loss of functional skills, and retain access to necessary communication supports.

I am attaching a letter from [Beneficiary]'s [type of treatment provider], [name], who has determined that this intervention is evidence-based and medically necessary due to [describe specific needs of the beneficiary that will be addressed by the service]. The intervention will address these needs by [describe what is involved in the intervention or service].

[Beneficiary] is not already receiving this service through the IDEA. I am attaching a copy of [his/her] most recent IEP. [Add details, if necessary, explaining why the service is different from those described in the IEP - e.g., the beneficiary is working towards different goals at school than those that the requested service would work towards; the beneficiary is only receiving the service during school hours and needs access to the same service outside school hours, etc.]

[Add more detailed information if possible. If you are including other documents such as prior assessments, include a list of what you are sending here.]

If you need additional information, I can be reached at [telephone number and/or e-mail address].

Sincerely,

[Signature]

[Typed Name]

You can either address the letter to:

1. The county welfare department shown on the Notice of Action;
2. The California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430;
3. To the State Hearings Division at fax number (916) 651-5210 or (916) 651-2789; or
4. Request a Hearing Online: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

Medi-Cal Adult Hearing Request Letter (New Service)

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

Re: [Name of Beneficiary], Member # [Member ID Number] Claim # [Claim Number]

To Whom It May Concern:

I am writing to request a Medi-Cal Fair Hearing for [Beneficiary]. [Beneficiary] is enrolled in [Medi-Cal Program or Managed Care Provider] in [County].

On [date], I received a letter denying [Beneficiary]'s request for coverage for [service] by [name of provider]. The reason for denial was listed as [reason listed for denial].

[Describe any previous efforts you may have made to appeal the decision internally.]

[Service] is medically necessary in order to ensure that [Beneficiary] can communicate effectively. I am attaching a letter from [Beneficiary]'s [type of treatment provider], [name], who has determined that this intervention is evidence-based and medically necessary due to [describe specific needs of the beneficiary that will be addressed by the service]. The intervention will address these needs by [describe what is involved in the intervention].

[Add more detailed information if possible. If you are including other documents such as prior assessments, include a list of what you are sending here.]

If you need additional information, I can be reached at [telephone number and/or e-mail address].

Sincerely,

[Signature]

[Typed Name]

1. The county welfare department shown on the Notice of Action;
2. The California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430;
3. To the State Hearings Division at fax number (916) 651-5210 or (916) 651-2789; or
4. Request a Hearing Online: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

Medi-Cal Adult Hearing Request Letter (Cut-off Service)

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

Re: [Name of Beneficiary], Member # [Member ID Number] Claim # [Claim Number]

To Whom It May Concern:

I am writing to request a Medi-Cal Fair Hearing for [Beneficiary]. [Beneficiary] is enrolled in [Medi-Cal Program or Managed Care Provider] in [County]. In order to ensure continuity of care, I am requesting aid paid pending the resolution of the hearing.

On [date], I received a letter saying that [Beneficiary] will no longer receive coverage for [service] by [name of provider]. The reason for denial was listed as [reason listed for denial].

[Note whether the beneficiary changed Medi-Cal plans within the past 12 months. If so, note whether the beneficiary had received these services through his or her previous plan].

[Describe any previous efforts you may have made to appeal the decision internally.]

[Service] is medically necessary in order to ensure that [Beneficiary] can communicate effectively. [Beneficiary] has already benefited from this service by [describe benefit] and is continuing to make progress toward [goal]. It is critical that [Beneficiary] continue to receive the service in order to continue making progress toward [goal], avoid loss of functional skills, and retain access to necessary communication supports.

I am attaching a letter from [Beneficiary]'s [type of treatment provider], [name], who has determined that this intervention is evidence-based and medically necessary due to [describe specific needs of the beneficiary that will be addressed by the service]. The intervention will address these needs by [describe what is involved in the intervention or service].

[Add more detailed information if possible. If you are including other documents such as prior assessments, include a list of what you are sending here.]

If you need additional information, I can be reached at [telephone number and/or e-mail address].

Sincerely,

[Signature]

[Typed Name]

1. The county welfare department shown on the Notice of Action;
2. The California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430;
3. To the State Hearings Division at fax number (916) 651-5210 or (916) 651-2789; or
4. Request a Hearing Online: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

Sample Letter - Private Insurance Pre-approval

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

Re: [Name of Beneficiary], Member # [Member ID Number] Claim # [Claim Number]

To Whom It May Concern:

I am writing to request pre-approval for [service] by [name of provider].

I have reviewed my policy and believe that [name of health care plan] is required to cover this service. [Service] is evidence-based and is medically necessary in order to ensure that [Beneficiary] can communicate effectively.

I am attaching a letter from [Beneficiary]'s [type of treatment provider], [name], explaining that this intervention is evidence-based and medically necessary due to [describe specific needs of the beneficiary that will be addressed by the service]. The intervention will address these needs by [describe what is involved in the intervention].

[For a continuing service, add:] As recommended by [treatment provider], I am requesting pre-approval for x hours/visits per day/week/month.

[Add more detailed information if possible. If you are including other documents such as prior assessments or other information, include a list of what you are sending here.]

If you need additional information, I can be reached at [telephone number and/or e-mail address].

Sincerely,

[Signature]

[Typed Name]

Sample Letter - Private Coverage Appeal

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

Re: [Name of Beneficiary], Member # [Member ID Number] Claim # [Claim Number]

To Whom It May Concern:

I am writing to request a review of your denial of my claim for [service] by [name of provider]. I received your denial letter on [date]. The reason for denial was listed as [reason listed for denial].

I have reviewed my policy and believe that [name of health care plan] is required to cover this service. [Service] is evidence-based and is medically necessary in order to ensure that [Beneficiary] can communicate effectively.

I am attaching a letter from [Beneficiary]'s [type of treatment provider], [name], explaining that this intervention is evidence-based and medically necessary due to [describe specific needs of the beneficiary that will be addressed by the service]. The intervention will address these needs by [describe what is involved in the intervention].

If applicable, add: [Beneficiary] is not already receiving this service through the IDEA. I am attaching a copy of [his/her] most recent IEP. [Add details, if necessary, explaining why the service is different from those described in the IEP - e.g., the beneficiary is working towards different goals at school than those that the requested service would work towards; the beneficiary is only receiving the service during school hours and needs access to the same service outside school hours, etc.]

[Add more detailed information if possible. If you are including other documents such as prior assessments, journal articles, or other information, include a list of what you are sending here.]

If you need additional information, I can be reached at [telephone number and/or e-mail address].

Sincerely,

[Signature]

[Typed Name]

NOTES:

NOTES: