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# Access to Communication Services and Supports: Concerns Regarding the Application of Restrictive “Eligibility” Policies

*National Joint Committee for the Communication Needs of Persons With Severe  
Disabilities*

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## About This Document

This technical report was developed by the National Joint Committee for the Communication Needs of Persons With Severe Disabilities and approved (EB 12-02) by the Executive Board of the American Speech-Language-Hearing Association in Spring 2002. National Joint Committee member organizations and their respective representatives who prepared this statement include the American Association on Mental Retardation, Mary Ann Ronski; the American Occupational Therapy Association, Jane Rourke; the American Speech-Language-Hearing Association, Beth Mineo Mollica, Rose Sevcik, Diane Paul-Brown (ex officio), and Alex F. Johnson (monitoring vice president); the Council for Exceptional Children, Division for Communicative Disabilities and Deafness, Lee McLean (chair); RESNA, Kevin Caves; TASH, Pat Mirenda and Martha Snell; and the United States Society for Augmentative & Alternative Communication, David Yoder.

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## Technical Report

The purpose of this technical report is to provide information supporting the National Joint Committee for the Communication Needs of Person With Severe Disabilities (NJC) position on *Access to Communication Services and Supports: Concerns Regarding the Application of Restrictive “Eligibility” Policies*. This report reflects an historical and interdisciplinary perspective on the issues presented. The organization of this report follows the order of statements in the position statement.

### **Eligibility policies and practices often preclude children and adults with severe disabilities<sup>1</sup> from accessing needed communication services and supports.**

In recent years, many state and local education agencies have instituted more restrictive eligibility criteria for speech-language services (ASHA, 2000). However, narrowing eligibility solely on the basis of categorical factors, such as diagnosis or mental age, violates the Individuals With Disabilities Education Act (IDEA) Amendments of 1997, which explicitly require that services be based on individual student needs that affect participation and progress in the general curriculum and extracurricular and other nonacademic activities. Further, these recent amendments require that particular emphasis be given to the special factors of communication needs, assistive technology devices and services, and positive behavioral interventions.

Similarly, for many years adults with severe communication disabilities were denied access to communication services and supports by state Medicaid programs solely on the basis of their age and the nature of their disability. Challenges to these denials have resulted in improvements in Medicaid funding for communication services and supports in many states. Recent revisions of Medicare policy also

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<sup>1</sup> Persons with severe disabilities include “persons with severe to profound mental retardation, autism, and other disorders that result in severe socio-communicative and cognitive communicative impairments” (National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992, p. 2)

recognize the legitimacy and therapeutic appropriateness of AAC interventions. Once denied by Medicare as “convenience items,” speech-generating devices (AAC devices) are now a covered benefit.

Despite these recent policy revisions and clarifications, there is considerable anecdotal evidence that local school districts and service agencies continue to base access to communication services on a priori judgments concerning the potential value or benefits of services provided to individuals with severe disabilities (e.g., McWilliam, Young, & Harville, 1996; Summers, 1999).

**Communication services and supports may be delivered through a variety of service delivery models<sup>2</sup>, and may include instruction of individuals and their communication partners, assistive technology, and environmental modifications.**

Justification for denial of communication services and supports for persons with severe disabilities is often based erroneously on a narrow concept that “communication” pertains only to the use of standard linguistic structures and traditional output modes (i.e., speech and writing). In actuality, “communication may be intentional or unintentional, may involve conventional or unconventional signals, may take linguistic or nonlinguistic forms, and may occur through spoken or other modes” (National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992, p. 3). Therefore, considerations of communication intervention should include multiple forms and modes based on a person's communication needs and preferences. Furthermore, because communication does not occur in a vacuum, communication intervention “... requires careful attention to and management of the physical and interpersonal environments in which such persons live, play, and work” (National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992, p. 3). This means that an individual's communication partners need to be directly involved in order for communication services and supports to be effective. To enable an individual's meaningful participation in daily activities, communication services and supports must be provided using the model(s) of service delivery most suitable for the individual (Cirrin & Penner, 1995; McWilliam, 1996; Paul-Brown & Caperton, 2001). Family members, friends and peers, teachers, and other service providers must feel comfortable and be knowledgeable about the ways an individual expresses him/herself (Beukelman & Mirenda, 1998; Downing, 1999; National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992).

**The expected outcome of such services and supports is an increase in the individual's meaningful participation in daily activities.**

The Communication Bill of Rights (National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992) states that all individuals have a right to communicate during their daily activities and across the

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<sup>2</sup> Service delivery models include both direct service and “indirect,” consultative/collaborative service models, and any combination of these models identified as most appropriate to meet the individual's needs (See Paul-Brown & Caperton, 2001).

lifespan. Individuals with severe disabilities express themselves in many ways, including speech, gestures, facial expressions, vocalizations, and body movements. There are also a number of symbolic but nonspoken modes of communication that may be used by individuals with cognitive, sensory, and/or motor disabilities. These modes, which include manual signs, picture communication systems, tangible symbol systems, and orthographic systems, may be produced with or without the aid of a speech-output communication device. Thus, the expected outcome of communication services and supports for individuals with severe disabilities should be functional and should reflect each individual's daily needs and preferences. Outcomes should not be defined exclusively in relation to the attainment of specific spoken language goals. Rather, outcomes should be considered relative to the *effectiveness* of communication—in the form and mode most appropriate for that individual (which is not necessarily spoken language)—in enabling the individual to participate more fully in the various settings and with the multiple communication partners encountered in daily life. In addition, reimbursement for services may derive from more than one funding source. Nevertheless, it would be contrary to current standards of professional practice, policy, and published literature to allow the setting, communication partner, or funding stream to dictate what constitutes an individual's “need” to communicate. Rather, effective communication enables an individual to participate in all facets of daily activity, and may impact—among other things—family and peer interaction, learning, self-care, employment, and community involvement. Effective communication has been demonstrated to enhance self-determination (Wehmeyer & Kelchner, 1995), personal perceptions of outcome (Wehmeyer, 1994), quality of life (Schalock, 1994), and social interactions (Kennedy, Horner, & Newton, 1990). Beneficial outcomes such as these result from services and supports provided directly to the individual as well as those provided to the individual's communication partners.

**Categorical denial of communication services and supports without consideration of a person's unique communication needs may violate federal statute, and may also violate state law, regulation, and policy.**

Very broad protections are provided under federal law for individuals who are eligible for special education services, vocational rehabilitation services, Medicaid, and/or Medicare. In all instances, availability of services—including communication services and supports—must be determined based on the individual's needs, and may not be denied solely on the basis of the nature or extent of the individual's disability (34 CFR 300.300).

State laws, regulations, and policies may offer more expansive benefits than those afforded to individuals under federal law, but may not reduce them below the level guaranteed by federal law.

***It is the position of the National Joint Committee for the Communication Needs of Persons With Severe Disabilities that eligibility for communication services and supports should be based on individual communication needs.***

**Communication services and supports should be evaluated, planned, and provided by an interdisciplinary team with expertise in communication and language form, content, and function, as well as in augmentative and alternative communication (AAC).**

The knowledge, experience, and skills of the individual, his/her family members, and several professionals are critical to the design and implementation of appropriate communication supports and services for the individual with severe disabilities. Teams must include at least one individual with expertise in language understanding and use, communication disorders, and AAC strategies. Further, such interdisciplinary teams may require the participation of an occupational therapist and a physical therapist when issues of positioning, seating, and/or motor skills affect an individual's ability to communicate effectively (Angelo, 1997). The specific nature of the individual's physical, sensory, cognitive, and communication needs will determine which other professionals need to be involved in the planning process. However, the mere involvement of professionals from a variety of disciplines, such as audiology, general and special education, occupational therapy, physical therapy, and speech-language pathology, does not insure their collaboration in providing relevant and necessary support services. The provision of communication services and supports is likely to be compromised if input from any single professional is not adequately synthesized and coordinated with input from the individual, the family, and other professionals (Giangreco, Dennis, Edelman, & Cloninger, 1994; Giangreco, Edelman, & Dennis, 1991; McCarthy et al., 1998; National Joint Committee for the Communication Needs of Persons With Severe Disabilities, 1992).

**Decisions regarding team composition, types, amounts, and duration of services provided, intervention setting, and service delivery models should be based on the individual's communication needs and preferences.**

Current recommended practice, based on recent research, supports the delivery of communication services in multiple settings, corresponding to the many actual environments in which the individual's communication must be functional (Mirenda, 1997; Wilcox & Shannon, 1996). For example, a special education student's communication needs do not depend on school attendance, but exist through the course of the student's day and year. In fact, time in school represents less than 20% of a typical student's waking hours during the course of a year. Thus, the communication services plan for that student might include objectives and criteria specific to a variety of important nonschool settings and communication partners. Similarly, for an adult receiving Medicare-funded communication services, the service delivery model and contexts should reflect the aspects of that individual's daily life in which improved communication may enhance participation—and not just the medical or clinical setting.

The remaining sections of this report address the issues associated with each of the eight a priori criteria—identified in the committee's Position Statement—invoked as a justification for denial of services and supports. These factors are addressed in sequence (a through h) with specific references to the empirical evidence, practice guidelines, and/or legal ruling or statute that precludes use of that factor as an a priori criterion in eligibility determinations.

**Eligibility determinations based on a priori<sup>3</sup> criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning;**

Individuals with severe disabilities are sometimes denied access to communication services and supports because their language skills are determined to be commensurate with their cognitive skills. This model, known as cognitive referencing, suggests that a language delay warrants intervention only when language skill development lags behind cognitive skill development (Miller & Chapman, 1980; Shane & Bashir, 1980). This notion has been refuted by research demonstrating that the relationship between language and cognition is neither straightforward nor static (Casby, 1992; Cole & Fey, 1996; Kangas & Lloyd, 1988; Notari, Cole, & Mills, 1992; Rice & Kemper, 1984); that tests purporting to assess cognitive and linguistic performance often measure the same fundamental skills (ASHA, 1999, 2000; Secord, 1992); that assessments typically used for deriving cognitive/language profiles yield sizable variation in discrepancy determinations (Cole, Dale & Mills, 1992); and that children with disabilities whose cognitive and language skills were commensurate nonetheless benefit from language intervention (Cole, Dale, & Mills, 1990). Given the lack of substantiation for cognitive referencing as a prognostic indicator, it should not be used as the basis for restricting access to communication services and supports.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; **(b) chronological age;**

Chronological age is often mentioned as an argument against the provision of communication services to individuals with severe disabilities, because they are either “too young” or “too old” to benefit from such services. Current research clearly documents the efficacy of communication services and supports provided to infants, toddlers, and preschoolers with a variety of severe disabilities (Bondy & Frost, 1998; Cress, in press; Ronski, Sevcik, & Forrest, 2001; Rowland & Schweigert, 2000). As children transition from preschool through primary and secondary education levels, they continue to develop language and communication skills (Chapman, 1997) and thus benefit from communication services and supports throughout the school years (Hamilton & Snell, 1993; Mirenda, Wilk, & Carson, 2000; Ronski & Sevcik, 1996).

One common argument against a particular type of communication service for toddlers and preschool-age children is that such children are “too young” to introduce the use of an augmentative/alternative communication (AAC) mode. Specifically, some parents and professionals believe that the introduction of an AAC mode at an early age will preclude the child from ever developing speech as his/her primary mode of communication. In fact, however, numerous studies have

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<sup>3</sup> a priori is defined as “made before or without examination and not supported by factual study” (American Heritage Dictionary of the English Language, 1981).

demonstrated that the use of AAC does not interfere with speech development (Romski, Sevcik, & Hyatt, in press) and actually has been shown to support such development (see Millar, Light, & Schlosser, 1999 for a review of research demonstrating this effect; Romski & Sevcik, 1996; Romski, Sevcik, & Pate, 1988). Nor do communication needs disappear when school services end; they remain or expand as children transition into adulthood and as young adults grow older. Communication permeates every aspect and cycle of life, influencing one's self-determination and life quality. Likewise, a number of studies have shown that individuals with severe disabilities continue to develop communication and language skills well into their adult years (McLean, Brady, & McLean, 1996); and that adolescents and adults with a variety of severe disabilities make measurable gains when provided with appropriate communication services (Iacono, Carter, & Hook, 1998; McLean & McLean, 1993; Romski, Sevcik, & Pate, 1988; Sack, McLean, McLean, & Spradlin, 1992). Communication is essential across the lifespan, thus it is inappropriate to restrict access to communication services and supports on the basis of chronological age.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) **diagnosis;**

The term “severe disabilities” is used to refer to numerous diagnostic labels that result in major communication, cognitive, motor, and/or sensory impairments. Further, significant limitations in communication often are secondary to a wide range of disability conditions or etiologies (e.g., chromosomal, genetic, metabolic, environmental, neurological; Batshaw, 1997). Contemporary research studies have demonstrated that, with appropriate instruction and support, individuals with severe disabilities can learn to communicate effectively regardless of the nature and/or cause of their underlying impairments. For example, research has demonstrated the benefits of appropriate instruction and support for individuals with autism (Hamilton & Snell, 1993; Mirenda, Wilk, & Carson, 2000; Wetherby, Prizant, & Schuler, 2000); individuals with severe cognitive and/or physical disabilities (McCathren, 2000; Romski & Sevcik, 1996; Rowland & Schweigert, 2000; Sack et al., 1992; Wacker, Wiggins, Fowler, & Berg, 1988); and individuals who are deaf-blind (Rowland & Schweigert, 1989, 1993). A diagnostic label, in and of itself, reveals very little about an individual's communication functioning, and thus is insufficient evidence on which to base a decision regarding access to communication services and supports.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) diagnosis; (d) **absence of cognitive or other skills purported to be prerequisites;**

Some practitioners and policy-setting agencies have interpreted research findings as suggesting that certain skill requirements or performance criteria are necessary for an individual to benefit from communication services or supports (Miller &

Chapman, 1980; Shane & Bashir, 1980). For example, research linking specific sensorimotor skills to language acquisition in typically-developing children was interpreted as suggesting that such skills are prerequisites for speech and language development in children with severe disabilities. Thus, students not demonstrating these skills were considered ineligible for direct communication services. Recent research has documented that children and adults who do not demonstrate these supposed prerequisites can benefit from appropriate communication services and supports (Brady & McLean, 2000; Kangas & Lloyd, 1988; McCathren, 2000; Reichle & Yoder, 1985; Ronski & Sevcik, 1996). Thus, access to communication services and supports should not be predicated on the demonstration of skills once considered to be prerequisites.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) diagnosis; (d) absence of cognitive or other skills purported to be prerequisites; **(e) failure to benefit from previous communication services and supports;**

Another argument that has been used to exclude individuals from communication services is that past services provided to the individual have not been successful in promoting improved communication skills. In such cases the tendency is often to attribute this failure to the individual's purported “lack of potential to benefit.” However, so many factors that may contribute to an individual's perceived failure to benefit from previous communication services and supports that failure cannot be attributed with certainty to the individual alone. These factors may include the selection of inappropriate intervention goals, insufficient instructional time, unsuitable or outdated intervention methods or materials, a failure to collect and analyze meaningful performance data, a failure to incorporate suitable assistive technology, a failure to recognize or address the needs and concerns of culturally / linguistically diverse families, as these might affect participation in communication services; and/or the use of irrelevant or erroneous criteria to evaluate intervention. An individual's perceived failure to benefit also may relate to health, environmental, or other factors that were not adequately considered in previous communication services and support. Thus, when considering potential services for an individual who reportedly has failed to benefit from past services, it is crucial that the team carefully review and analyze all aspects of past services in order to identify specific modification(s) that have the greatest probability of yielding improved outcomes for the individual, and then implement those improvements with ongoing monitoring of progress (McCarthy et al., 1998; Wilcox & Shannon, 1996). Access to communication services and supports should not be denied merely because an individual failed to progress as a function of prior therapy; rather, previous experiences should be examined in order to determine ways in which communication services and supports could be better tailored to meet the individual's unique communication needs.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c)

diagnosis; (d) absence of cognitive or other skills purported to be prerequisites; (e) failure to benefit from previous communication services and supports; **(f) restrictive interpretations of educational, vocational, and/or medical necessity...**

Funders of communication services and supports, such as school districts, vocational rehabilitation agencies, and public or private insurers, employ criteria to determine whether they are legally obligated to pay for a needed service, device, or other support. A funder may impose inappropriately restrictive interpretations of the relevant laws or policy as justification for denial of services. The only protection against this inappropriate practice is for the individual and/or the advocate to have specific knowledge of the statute or policy and any related case law or policy determinations arising from them.

For example, if a student receives special education services, a communication service/support must be provided if it enables the youngster to receive a “free, appropriate public education” in the “least restrictive environment.” It is very difficult to deny the critical importance of communication in the education setting; thus it should be very difficult for a school to deny access to communication services and supports for children with significant communication limitations. The services and placement needed by each child with a disability must be based on the student's unique needs and not on the student's disability (34 CFR Part 300.300). The IDEA also explicitly states that the need for assistive technology devices and services must be considered for all students when developing the Individualized Education Program (20 U.S.C. §1414 (d)(3)(B)(v); 34 CFR 300.3346(a)(2)(v)).

Communication limitations are typically secondary to medical problems that have resulted in a malformation or malfunction of the brain or other physiological components in the communication chain (Crystal & Varley, 1998). Thus, treatment for the sequelae of such medical problems is considered medically necessary. Not all children have health insurance coverage (private insurance or public insurance such as Medicaid) for reimbursement of treatment costs, so at times schools may have to provide devices if the devices are determined to be educationally necessary in addition to being needed to treat a medical condition or its consequences. Federal law, however, states clearly that Medicaid has primary responsibility when some overlapping health and education service need is identified (42 USC 1396b(c)).

Adults may qualify for communication services and supports from a variety of sources, including private insurance, Medicaid, vocational rehabilitation agencies, and Medicare. Depending on the terms of the coverage, individuals may be able to access communication services and/or supports as durable medical equipment (DME), prosthetic devices, and/or speech-language pathology services. Although Medicaid coverage for adults varies from state to state, all states include DME as a covered benefit. Forty-eight state Medicaid programs provide reimbursement for prosthetic devices, and about two-thirds of the states cover speech-language pathology services. Medicare covers communication services and supports as speech pathology services and speech generating devices (Medicare Coverage Issues Manual, §60-23; DMERC A, B, C, D, Regional Medical Review Policy on Speech Generating Devices).

Vocational rehabilitation funds may be accessed for purchase of communication services and supports if the consumer's use of them is linked to vocational outcomes. In some states, independent living funds also may be used to pay for services and supports that will improve the individual's “ability to function, continue functioning, or move toward functioning independently in the family or community or to continue in employment” (Section 7(15)(B) of the Rehabilitation Act).

To qualify for services under vocational rehabilitation, an individual must have a disability that presents a barrier to employment and must be willing to pursue vocational goals and employment (Rehabilitation Act of 1973, as amended, Title I, Sections 100–111). The Rehabilitation Act specifies that the burden of evidence is not on the client/advocate to demonstrate “employability” (a criterion for access to most vocational rehabilitation services), but rather on the vocational rehabilitation agency to demonstrate that the individual is not employable, even with appropriate accommodations, if the agency wishes to deny access to services.

Both private insurance and public insurance programs (Medicaid and Medicare) require the beneficiary to demonstrate how the communication services and supports are medically necessary. Such justification should document that communication services and supports are needed to accommodate the loss of function of a body part, typically as the result of a physical defect or medical condition (e.g., severe apraxia secondary to brain injury, unintelligible articulation as a function of cerebral palsy, severe communication disability secondary to mental retardation of unknown etiology). Medical care is provided to restore health following identification of impairment. Thus, the need for treatment is not based on how the person will then use his/her functioning after it is restored, and certainly is not appropriately measured by whether those uses involve other funding programs, such as school or vocational rehabilitation.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) diagnosis; (d) absence of cognitive or other skills purported to be prerequisites; (e) failure to benefit from previous communication services and supports; (f) restrictive interpretations of educational, vocational, and/ or medical necessity; **(g) lack of appropriately trained personnel;**

Surveys repeatedly show that even experienced professionals feel that they lack the skills required to provide communication services and supports to individuals with severe disabilities (ASHA, 2000; King, 1998; Ogletree, Sportsman, VanGiesen, & Siegel, 2000; Simpson, Beukelman, & Bird, 1998). A fundamental tenet of IDEA and professional associations is the need to have adequate training to provide appropriate communication services and supports (e.g., AAMR, 2001; AOTA, 2000; APTA, 1981, 2001; ASHA, 2001; CEC, 1997; TASH, 1999). Professionals can only serve persons with severe disabilities if they have knowledge and skills specific to this population (McCarthy et al., 1998). Holding professional licensure or certification does not ensure expertise in meeting the communication needs of persons with severe disabilities. It is the responsibility of the professionals on the team to have the knowledge and skills necessary to serve

this population. If the team lacks adequate expertise, including competence relative to cultural and linguistic diversity (Huer, Parette, & Saenz, 2001; Kemp & Parette, 2000; Saenz, Huer, Doan, Heise, & Fulford, 2001), alternative sources of expertise must be secured, or sufficient training for the existing team must be obtained. To do otherwise, individual team members would violate professional codes of ethical conduct. However, lack of trained personnel is not justification for denying services or providing inadequate services and supports. Rather, if sufficient numbers of qualified personnel are unavailable, the agency has an obligation to secure appropriate training for existing staff or to secure additional staff with the needed expertise (*Timothy W. vs. Rochester, NH School District*, 1989). The mere lack of trained personnel cannot be used as a reason to deny access to communication services and supports; rather, if the individual's communication needs indicate that such supports are warranted, the responsible provider is obliged to secure personnel with sufficient knowledge and skills to provide quality services.

Eligibility determinations based on a priori criteria violate recommended practice principles by precluding consideration of individual needs. These a priori criteria include, but are not limited to: (a) discrepancies between cognitive and communication functioning; (b) chronological age; (c) diagnosis; (d) absence of cognitive or other skills purported to be prerequisites; (e) failure to benefit from previous communication services and supports; (f) restrictive interpretations of educational, vocational, and/or medical necessity; (g) lack of appropriately trained personnel; and **(h) lack of adequate funds or other resources.**

The provision of appropriate communication services and supports for individuals with severe disabilities may require resources beyond those currently available or allocated within a local education agency or other service provider agency. For example, a community service agency may voice concern that the communication services recommended for one client with severe disabilities would present an impossible drain on that agency's budget. Similarly, a rural school district may indicate that it cannot provide appropriate communication services for a student with severe disabilities because it has not been able to hire one or more needed professionals for the student's team (e.g., an occupational therapist, physical therapist, or speech-language pathologist). Although each of these cases may represent real challenges for the agencies involved, such perceived or real barriers do not constitute legal grounds for denial of services when services are mandated by federal statute.

It is important to note that the lack of adequate resources to provide appropriate communication supports and services may be more of a perceived barrier than an actual one. For example, one recent study dispelled the perception that *funding* was the primary barrier to provision of AAC devices and services by demonstrating that such funding was available through a variety of public and private benefits programs (Mineo Mollica, 1999). Likewise, an agency may not have the necessary expertise within its own professional staff to meet the needs of a particular client, but may be able to access the needed knowledge and skills through interagency agreements and/or contractual services. Thus, what appears to be a lack of financial or personnel resources may actually be a lack of information about how and where to access the needed resources to provide appropriate communication services and

supports. It is illegal under Medicaid law and under the Individuals with Disabilities Education Act to subject individuals to undue delays in the provision of services to which they are entitled. Also, there is nothing in either program that permits restrictions in services due to budget limitations. Rather, both Medicaid law and IDEA state that identified needs have to be met.

## Summary

This report has provided a brief summary of the legal and empirical bases for the position statement adopted by the National Joint Committee for the Communication Needs of Persons With Severe Disabilities. This position states that decisions about eligibility for communication services and supports for an individual with severe disabilities, as well as decisions about the nature and extent of those services, must be based upon consideration of an individual's communication abilities and needs, and not on any other a priori criteria.

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