Juvenile Detention Alternatives Initiative Moving Forward in SD

by John A. Hamilton

The Juvenile Detention Alternatives Initiative’s (JDAI) goal is to safely reduce the unnecessary and inappropriate detention of youth. Minnehaha and Pennington Counties have become pilot sites for the JDAI in South Dakota. This initiative requires the sites to adopt certain core values regarding conditions of confinement. One of these core values is that children must be held in conditions that meet constitutional and statutory legal requirements, as well as best professional standards of practice.

History of JDAI

The JDAI, while relatively new to South Dakota, is an effort that began in 1992. JDAI noted that many juvenile detention centers provided inadequate and dangerous conditions, harming the youth and opening public officials to liability. Facilities also encountered overcrowding, which makes conditions worse for all involved. Studies showed approximately 20% of juveniles were held in secure confinement at some point between referral and disposition and have been subject to abuse and mistreatment. There were substantial deficiencies in living spaces, health care, security, and suicide prevention. There were also concerns regarding educational and treatment services, and use of isolation and restraint. More recent studies had nearly identical findings.

JDAI wanted to ensure facilities met constitutional and statutory requirements and standards of best professional practice. The Youth Law Center and others were asked to perform facility assessments of JDAI’s initial five sites. As JDAI grew, the inspection process became unworkable because the experts did not have time to inspect dozens, or what would become hundreds, of juvenile detention centers across the country. JDAI asked the Youth Law Center (San Francisco) and the Center for Children’s Law and Policy (Washington, D.C.) to design a locally-based, comprehensive assessment process that would provide facilities with objective, standards-based feedback. In developing the standards and content of the assessment, these agencies also obtained feedback from several national experts.

The agencies completed the original standards in 2004. They revised the standards in 2006 based on feedback from the JDAI sites and law revisions. The standards and assessment incorporate constitutional requirements and case law, federal statutes and regulations (such as

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the Juvenile Justice Detention Protection Act (JJDPA), individuals with Disabilities Education Act (IDEA), Section 504 of the Rehabilitation Act, Americans with Disabilities Act (ADA), Title IX, and Religious Land Use and Institutional Practices Act (RLUIPA), professional standards of best practice, and the values of JDAI. These standards evolve over time as best practices continue to develop; the Youth Law Center is currently working on a new revision. With the standards and assessment in place, the Youth Law Center now trains assessment teams across the country.

History of JDAI in South Dakota

The South Dakota Council of Juvenile Services (CJS) sought out JDAI because South Dakota was leading the nation in youth incarcerated per capita. The detention numbers tend to fluctuate based on which judge was assigned to juvenile cases in a given year. Not only is overcrowding detrimental to both youth and staff, but South Dakota’s high numbers of incarcerated youth was also expensive. As its name suggests, JDAI (Juvenile Detention Alternatives Initiative) promotes and has standards requiring alternatives to detention for many youth who had been previously detained. CJS chose 2 pilot sites, Minnehaha and Pennington Counties, to begin implementing JDAI standards in South Dakota. CJS reached out to the leaders in each community to verify their willingness to participate. It would be difficult, if not impossible, to implement JDAI standards if the community leaders did not support it.

Each site formed a policy steering committee in 2010 and hired a JDAI Coordinator by January 2011. During 2011, each site had workgroups that developed a Risk Assessment Instrument (used at intake and on an ongoing basis to determine whether detention is or remains appropriate), explored Alternatives to Detention for youth who did not score high enough on the Risk Assessment to warrant detention (such as placement in a lesser restrictive setting, home detention with a leg monitor, or simply sending the child home pending court adjudication), and made Case Processing changes (which allow the Risk Assessment to be completed in another location or over the phone; as a result, youth who do not score high enough to warrant detention never have to step foot in the detention facility).

With the coordinators hired and procedures in place, live implementation of JDAI standards at the pilot sites began in January and February 2012. The sites began using the Risk Assessment Instrument and implementing use of the Alternatives to Detention. The sites also hired a Placement Coordinator/Expediter to assist in the case process. As a result, the number of youth incarcerated in Minnehaha and Pennington Counties has decreased significantly. In March 2012, the JDAI Coordinators began assembling the JDAI Juvenile Detention Facility Assessment Teams for their respective sites. Ken McFarland, Commission Administrative Officer and Co-Chair of the JDAI Project for Minnehaha County, stated: “The Minnehaha County Commission is deeply impressed by the commitment and support of the core principles and values of JDAI by community leaders and those in the juvenile justice field. Their efforts to
implement JDAI in our community have had a significant impact in reducing the number of juveniles in secure detention and implementing alternatives that have significantly better results for the youth of our community.

**JDAI Juvenile Detention Facility Assessment**

To make sure that children are held in conditions that meet constitutional and statutory legal requirements, as well as best professional standards of practice, the JDAI sites agree to participate in the “Juvenile Detention Facility Assessment,” which means facilitating the assessment process, accepting the Assessment Team report, developing a corrective action plan to address any deficiencies, and implementing any needed changes. The JDAI Juvenile Detention Facility Assessment is completed by volunteer assessment teams composed of juvenile justice and human services professionals, youth and families involved with the system, representatives from community organizations that work with youth, and professionals working in areas of education, medical care, and mental health. South Dakota Advocacy Services (SDAS) employees, Dianna L. Marshall, PALIM Program Director (Rapid City); and John A. Hamilton, Legal Affairs Director (Sioux Falls), are participating on the Pennington and Minnehaha County assessment teams.

Erin Srska and Liz Heidelberger are JDAI Coordinators, respectively, for Minnehaha and Pennington Counties. They have essentially four duties with completing the assessment process: assembling the assessment team; coordinating training for the team; working with the detention facility administrator to discuss the assessment and coordinate dates; and coordinating the assessment process. The assembled Juvenile Detention Facility Assessment Teams met June 14 and 15 for training by the Youth Law Center on JDAI’s standards for safe and humane detention facilities, and how to prepare for and conduct a facility assessment, prepare a report, and monitor implementation. In addition, detention facility administrators from not only Minnehaha and Pennington Counties, but all detention facilities in South Dakota, participated in the training to learn more about the JDAI standards and the assessment process. Marshall commented, “I thought the training was very informative and I appreciated the trainers from the Youth Law Center sharing their experiences and insights in conducting juvenile facility assessments.”

The assessment process is very comprehensive, following the acronym “CHAPTERS.” The following describes many of the items the Assessment Teams will review in each area:

**Classification and Intake System** - addresses what happens when youth enter the facility with the goals of keeping youth safe and reducing crowding and unnecessary detention. The Assessment Team will look at whether admissions criteria limits detentions to serious offenders and flight risks, the intake process, risk assessment, race, and mental health and educational status, orientation process, and how youth are separated based on individual factors and needs.

**Health and Mental Health Care** - the goal is that medical conditions that need treatment or place youth at risk are immediately discovered through admissions screening, and ongoing treatment is provided during the youth’s detention. The Assessment Team will look at the admission screening process, whether mental health assessments are performed and performed in a timely manner, mental health screening, follow-up, and if youth receive evaluation to monitor when needed. The Assessment Team will also look at staff training, sick call availability, availability of other types of treatment, and discharge planning. It will also evaluate availability of emergency services, community services, ongoing mental health treatment, administration of prescription medication, and maintenance of medical records.

**Access Issues** - the goal is to promote success for youth by linking them to supportive relationships with family and others through use of the telephone, mail, and visitation, as well as providing access to legal counsel and the court system. The Assessment Team will also look at visitation policies for immediate family, as well as other friends and relatives. It will also review youth’s access to confidential legal assistance, including mail, phone calls, and visitation.

**Programming, Education, and Recreation** - the goal is that youth participate in age-appropriate, healthy, educational activities and are motivated through positive reinforcement and good behavior incentives. In the area of education, the Assessment Team will look at things such as staffing levels, teacher qualifications, hours of education provided, assessments, compliance with IEPs, library access, curriculum and whether it is appropriate for obtaining a high school diploma, credits, and services for youth with limited English proficiency. The Assessment Team will also look at teaching staff are actually teaching, rather than supplying homework packets for youth to complete on their own. In the area of special education, the Assessment Team will look at areas such as training of staff and related services are available, whether IEPs are being followed, whether certified staff provide special education and related services, and whether children with disabilities are provided transition services. The Youth Law Center asked Assessment Team members to answer the question, “Would I want my child to attend this school?” The Assessment Team will also review exercise, recreation, and other types of programming, whether children have opportunities to participate in religious activities, and the facility’s positive behavior management program.

**Training and Supervision of Staff** - The goal is for properly qualified staff to be hired and to receive needed training and support so they are able to do their work well. The Assessment Team will look at whether staff meets certain qualification standards, sufficient staffing levels, and capability for serving limited English proficient youth. It will look at pre-service, in-service, and ongoing training and the curricula of that training. It will also look at methods used for staff supervision, procedures for conduct violations, and procedures for youth and staff to report incidents.

**Environmental Issues** - The goal is for facilities, as much as possible, to provide a non-penal environment appropriate for youth who need to be held in a secure setting that meets all safety codes and provides a respectful quality of life for youth. The
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Assessment Team will look at whether the facility provides a positive atmosphere where youth and staff are treated with respect, the facility is well-maintained and non-penal to the extent possible, and staff wear casual uniforms. It will look at whether the facility is sanitary and youth are allowed to shower daily, brush their teeth, wash their hands, and wear clean appropriate clothing, as well as if there are sufficient ratios of toilets, sinks, and showers. The Assessment Team will also look at the food service and whether special dietary requirements are met, indoor temperature, ventilation, noise levels, lighting, and emergency preparedness and fire safety. Finally, it will look at how searches are conducted, whether there is overcrowding, and if youth are provided sufficient privacy.

Restraints, Isolation, Due Process, and Grievances – the goal is in confrontation situations, physical force, restraints, or isolation are used only when truly needed, and only as long as needed, and that youth are protected by due process and a grievance system. The Assessment Team will look at whether staff receive regular training in conflict management, de-escalation, crisis intervention, and management of assaultive behavior, and use a graduated set of interventions before using physical force. It will look at when restraints are used and the types of restraints used, as well as the procedures used when restraints are used. The Assessment Team will also look at use of isolation and room confinement, the facility’s due process protections for major rule violations, and the availability and procedures for filing and investigating youth grievances.

Safety for Youth and Staff – the goal is that safety is the principle underlying all other JDAI assessment sections. The Assessment Team will look at the procedures used to ensure youth safety from assaults by other youth or staff, and ensure staff safety from assaults by youth. It will also look at procedures for addressing harassment and intimidation, and ensuring there are no weapons in the facility.

As applicable to each of these areas, the Juvenile Detention Facility Assessment Teams will be reviewing policies and procedures and comparing them to JDAI standards, reviewing a number of documents, and interviewing staff, youth, family members, and applicable professionals. Some assessments will necessarily occur during various times of day, depending on what is being assessed (e.g., during intake, visitation, programming, meals, and at night). Erin Srstka and Liz Heidelberger have included individuals from a variety of professional backgrounds on the Assessment Teams, which I am sure will help when conducting the assessment of the facility with regard to the JDAI standards,” stated Marshall. Once the Assessment Teams complete the assessments in each area, they will also create a narrative report containing findings and recommendations. The Assessment Teams/JDAI Coordinators will present the Assessment Reports to the counties’ Steering Committees in September 2012. The JDC facilities will develop and implement corrective action plans to address items not meeting JDAI standards.

Benefits of JDAI Juvenile Detention Facility Assessment

The Juvenile Detention Facility Assessment is not intended as a game of “gotcha.” Rather, it is a process wherein a fresh set of eyes reviews the facility based on the JDAI standards, with the ultimate goal of providing safe, appropriate services to those youth who require placement in the facility. There are several benefits that will result from the Juvenile Detention Facility Assessment:

- The Assessment provides baseline data for purposes of measuring progress;
- It identifies and addresses problems/issues before something bad occurs;
- Facility Administrators can use assessment information to leverage additional resources;
- The JDAI process can improve and strengthen local and state facility regulations and inspections;
- By participating in the assessment process, community members learn how the detention center operates, its strengths and challenges, and can become ongoing resources to the detention center and children; and
- Most importantly, the assessment helps to ensure children who need to be detained are held in safe and humane conditions.

Youth with disabilities are particularly susceptible to inadequate care and treatment in juvenile detention settings, as well as physical harm and intimidation. The Assessment Teams will be looking at standards specifically relating to youth with disabilities in a number of the assessment areas. The Youth Law Center presenters seemed impressed that South Dakota Advocacy Services is represented on both teams, as they specifically sought us out to introduce themselves and thank us for participating. They were also impressed

Pictured l-r: John A. Hamilton, SDAS Legal Affairs Director; Erin Srstka, JDAI Coordinator for Minnehaha County; Liz Heidelberger, JDAI Coordinator for Pennington County; and Dianna L. Marshall, SDAS PAIMI Program Director.

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Erin’s Run Memorial 5K
by Marie McQuay

The day was cold and rainy, but that did not deter more than 450 people from coming together to celebrate a life and to fund a very good cause. My husband and I were privileged to be able to take part in “Erin’s Run,” which started at Memorial Park, headed east past Roosevelt Park to the Pennington County Fairgrounds, and back again. This was the third annual run in memory of 16-year-old Erin Sorenson, who died in a car accident in April of 2002. One hundred percent of the money raised goes to “Meeting the Need,” a fully accessible summer camp for people with disabilities, located in the heart of the Black Hills and only minutes from Mt. Rushmore. The first year, Erin’s Run raised $3,000. The second year, it raised $4,000. This year, $5,000 was raised and will be donated to Meeting the Need.

Meeting the Need was motivated by the personal experiences of Dallas Dietrich, who was injured in an automobile accident in 1997. Meeting the Need was started with a unique vision, which was “to provide an adventure retreat for people with disabilities in a historic mining environment that is totally handicapped accessible.” Meeting the Need is located at 13380 Greyhound Gulch Road, Keystone, SD. For further information, go to www.meetingtheneed.com.

Abusing Accessible Parking
by Norma Vrondian

I had never given much thought to accessible parking, other than being glad it was there for people who needed it. Now that I have to use accessible parking, I have a greater appreciation for what individuals have to go through who utilize it on a daily basis.

In one instance, I pulled into an accessible spot on the street. A local cab driver pulled up behind us, jumped out of his cab, and came over and asked us if we were going to move. We had just gotten there, plus there was an open designated accessible spot in front of us, so we told the cab driver “no.” This cab driver became rude and vulgar, whipped his cab around us, and parked parallel in a horizontal-type spot. He had an accessible parking placard in his cab; however, his “fare” came running out of the store, got into the cab, and drove away. It appeared that he was using his accessible placard to pick up his fare closer to the store entry.

It happens frequently that there are not enough accessible spots available and some people needing the closer parking spot have to wait for someone to leave, turning a quick trip to the store into hours of frustration.

Obtaining a placard is free if you qualify. A doctor must authorize the placard. You can get the necessary paperwork from your physician, from the county treasurer’s office, or by printing it from your home computer, at https://www.state.sd.us/eforms/secure/eforms/F0865V6-AppForDisabledParkingAppro.pdf.

To be eligible for a placard/plate, your doctor must be able to document that you meet one of the qualifying criteria:
- unable to walk more than 200 feet without stopping to rest;
- use oxygen;
- assisted by brace, cane, crutch, other person, prosthetic device, wheelchair, or other types of devices in order to walk;
- lung disease or a cardiac condition that meets criteria; or
- severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition.

South Dakota takes accessible parking seriously. If you are caught using false or fraudulent information on your application, you can be facing a $1,000 fine. If you are caught parking in an accessible spot without a placard, the fine is $100. The fine is also $100 if the person who the placard belongs to is not in the vehicle. If you block an accessible spot, you can also be fined $100. Additionally, there is a 30-day time limit to return the card if the qualifying person dies, or is no longer is disabled.

For more information on obtaining a disability placard/plate, call the South Dakota Coalition of Citizens with Disabilities at (800) 210-0143. One may also contact the Division of Motor Vehicles at (605) 773-3541. If you see someone abusing accessible parking, you can call your local police department.
Fetal Alcohol Spectrum Disorders – Personal Perspectives to Broaden Your Horizons

by Tina Agle

On March 13-14, 2012, the Chiesman Foundation for Democracy, Inc. / Fetal Alcohol Spectrum Disorders Center held the “Fetal Alcohol Spectrum Disorders: Personal Perspectives to Broaden Your Horizons” Conference at the Ramkota Convention Center in Rapid City, SD. This conference had several prominent speakers who are considered experts in their fields. These speakers not only educated the conference attendees on Fetal Alcohol Syndrome Disorders (FASD), but also on prevention of FASD, services for individuals with FASD, and how to work with individuals with FASD for positive outcomes. FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. FASD is America’s leading preventable birth defect.

The Chiesman Foundation for Democracy, Inc. is a non-partisan, nonprofit organization. It promotes and supports greater awareness of democratic ideals by providing programming for civic participation, education, and research. The foundation received a grant from the Department of Health and Human Services to create a Fetal Alcohol Spectrum Disorders Center. This FASD Center is a clearinghouse for information dissemination and an outreach center to help educate the community on FASD and its impact on South Dakota. It was announced at the conference the foundation’s grant was ending, but the community hoped the foundation would find a way to keep the FASD Center running and keep educating the public about FASD and its prevention. [Currently, the FASD Center is still providing information and publications, but has curtailed training because it has not found additional grant money.]

The first speaker, Edward Riley, Ph.D., is the Director of the Center for Behavioral Teratology at San Diego State University. Teratology is the study of birth defects. He presented “The Effects of Prenatal Alcohol Exposure on the Brain and Behavior.” Riley discussed alcohol’s connection to birth defects and how all FASD is preventable. He showed how FASD is among the most commonly known causes of cognitive impairments and is a major public health problem. FASD is not the only cause of cognitive impairments; however, if a mother uses alcohol during her pregnancy, impairments may occur. According to Riley, it is important to note that FASD is a physical brain deformity.

FASD can cause deformities including a pre/postnatal growth deficiency, specific pattern of facial features, and central nervous system dysfunction. There are several facial characteristics used by clinicians to help identify children who may have FASD. These include: short palpebral fissure; indistinct philtrum; thin upper lip; epicanthal folds; low nasal bridge; minor ear anomalies; and micrognathia. Several Neurodevelopmental Disorders called “ARND” (Alcohol Related Neurodevelopmental Disorders) have been linked to FASD. These include: basic physical effects such as feeding deficits or sensory-motor problems; deficits in attention; fine motor skill deficits; cognitive deficits such as a reduction in IQ; social and emotional deficits; and mental health issues such as depression or conduct disorders. It is very important to remember that a child who suffers from FASD is unlikely to show any of the physical features and may exhibit only emotional or cognitive deficiencies. Riley presented research showing that similar defects were found in animals exposed to alcohol while in gestation.

Riley’s presentation focused largely on the differences in brain development of children with FASD versus children who have not been exposed to alcohol while in the fetal stages. Some FASD brains exhibit anomalies that are fairly obvious, but these are very rare. The central nervous system abnormalities observed in FASD brains included an Agenesis of the Corpus Callosum, Schizencephaly, Lissencephaly, and Heterotopia. Agenesis of the Corpus Callosum is when there is a complete or partial absence of the Corpus Callosum, which is the band of white matter connecting the two hemispheres of the brain. Schizencephaly is a rare grey matter malformation of the brain. Lissencephaly means smooth brain; it is a brain formation disorder resulting in a lack of development of brain folds and grooves. Heterotopia is the displacement of an organ from its normal position. Children with these kinds of brain anomalies are typically referred to as children with Dysmorphic FASD.

Diane Malbin, M.S., Director of FASCETS, Inc., presented on several topics regarding FASD. FASCETS, Inc. is a nonprofit organization in Portland, Oregon, that is based on a neuro-behavioral model. Malbin presented “Linking Brain Function with Behavior: Understanding and Application of a Neuro-behavioral Approach,” “Good Technique, Poor Fit? Trying Differently Rather than Harder?,” and “Application of a Neuro-behavioral Approach: Developing Person-Specific Accommodations.” Malbin focused on screening for FASD and how to assist professionals in knowing the signs and characteristics of FASD. She encouraged professionals to focus on the strengths, not just the weaknesses, of their students or clients with FASD. She discussed the problems with multiple diagnosis and fragmentation of FASD.

Malbin also mentioned secondary characteristics, which are secondary defensive behaviors developed over time when there is a poor environmental or social fit for the person with FASD. Some secondary behavioral symptoms include: easily tired; anxious; lonely; flat affect; fearful; withdrawn; depressed; frustrated; short fuse; and anger. These symptoms often lead to trouble in school, social services involvement, addictions, mental health issues, or suicide. Due to these hurts people with FASD face, Malbin encourages those who work with children that have FASD to think outside of the box and attempt to understand that the person with FASD may not be functioning at the level they are thought to be.

Mary DeJoseph, D.O., is Adjunct Faculty at the Philadelphia College of Osteopathic Medicine. She presented “Connecting with Women at Risk,” DeJoseph provided examples of how

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The Early Intervention Program of the Individuals with Disabilities Education Act (IDEA), also known as Part C, is a $436 million federal program administered by states to provide services to infants and toddlers ages birth to three with developmental delays or who have been diagnosed with physical or mental conditions that have high probabilities of resulting in developmental delays. It is estimated that Part C serves over 340,000 infants and toddlers a year. In order for a state to participate in the program, it must assure that early intervention will be available to every eligible child and the child’s family. Currently, all states and eligible territories are participating in the Part C program.

Congress established the Part C program in 1986 in recognition of "an urgent and substantial need" to: enhance the development of infants and toddlers with disabilities and to minimize the potential for developmental delays; reduce the risk of institutionalization; reduce the costs of education by providing services early to infants and toddlers with disabilities; enhance family capacity to meet the special needs of infants and toddlers with disabilities; and enhance the capacity of state and local agencies and service providers to identity, evaluate, and meet the needs of this historically underrepresented population, particularly minority, low-income, inner-city, and rural populations.

On September 6, 2011, the U.S. Department of Education revised the Part C regulations as a result of statutory changes to IDEA in 2004. They were published in the Federal Register on September 28, 2011, and became effective on October 28, 2011. According to the U.S. Department of Education, some of the highlights of the regulations include: restructuring of the current regulations; reduced burden on states; increased state flexibility; much requested and needed clarification on complex decisions; ensuring state accountability for child find and provision of early intervention services; and aligning Part C, where practicable, to the Part B regulations.

In a video by the Office of Special Education and Rehabilitative Services, Assistant Secretary, Alexa Posny, highlighted some of the major changes to the Part C regulations and the rationale behind them. She explained the changes were made in an attempt to simplify the language of the regulations and increase the efficiency of the IFSP process for states, as well as ensure that all children who qualify for Part C services are receiving a free appropriate public education through child find and necessary procedural safeguards. While Posny discussed a variety of changes, this article focuses solely on those made to the procedural safeguards section.

The National Early Childhood Technical Assistance Center ("NECTAC") explains that procedural safeguards are required by the IDEA to protect the interests of families and children with special needs, including both special education and early intervention systems ("EIS"). "Procedural safeguards are the checks and balances of the system. Early intervention and special education personnel are legally obligated to explain procedural safeguards to families and to support an active adherence to and understanding of these safeguards for all involved." The procedural safeguards section of the Part C program begins at 34 CFR § 303.400.

General Responsibility of Lead Agency
- 34 CFR § 303.400

34 CFR § 303.400 discusses the general responsibility of a lead agency. The lead agency is a state-designated organization, agency, or office that is selected to administer and enforce Part C of IDEA. The lead agency continues to be responsible for establishing or adopting procedural safeguards that meet the requirements of the federal regulations and ensuring their effective implementation. The new regulations, at §303.400(a), lay out exactly where to find information regarding certain procedural safeguards, including confidentiality, parental consent and notice, surrogate parents, and dispute resolution procedures. Although many states do so already, the U.S. Department of Education (herein "the Department") included as a general responsibility of the lead agency to make an initial copy of the child's early intervention record available to parents at no cost. 34 CFR § 303.400(c). Parents continue to have the opportunity to inspect and review all Part C early intervention records that have been collected during the Part C process. 34 CFR § 303.400(b)(2).

Confidentiality - 34 CFR § 303.401

The Department clarified that the Part C confidentiality procedures apply from the point in time when the child is referred for early intervention services.” This means the confidentiality procedures of Part C DO NOT apply to an initial referral source and only take effect from that point forward. 34 CFR § 303.401(e)(1)-(2). The lead agency must disclose to the SEA ("state education agency") and the LEA ("local education agency") where the child resides, as well as certain identifiable information in order to provide for a smoother transition into the Part B program once the child "ages out" of Part C. 34 CFR § 303.401(d)(1)-(2). Previously, the lead agency required affirmative parental consent prior to disclosure of this identifiable information. Now, the regulations allow for an "opt-out" option, wherein parents are given notice that their child's identifiable information will be given to their respective LEA and SEA, but offers the parents a specified time to object to the disclosure. 34 CFR § 303.401(e).

Notice to Parents - 34 CFR § 303.404

When a child is referred to the Part C program, the lead agency is required to give notice to the parent and fully inform him/her of the requirements discussed in 34 CFR § 303.402. This includes a description of the child whom personal information is sought, exactly what types of information is needed, and the method in which to retrieve that information. This notice must also have a summary

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of the policies and procedures for retention, storage, disclosure to
third parties, and the destruction of this personal information, as well as
parental and children's rights to this information under Part
C. This notice must be provided in the parent's native language
unless "it is clearly infeasible to do so." 34 CFR § 303.404(a)-(d).

Access Rights & Records
- 34 CFR §§ 303.405-409

A major change to the Part C procedural safeguards section is
the length of time a participating agency has to provide parents
access to any records relating to their child that are "maintained,
collected and used" as part of that child's involvement in Part C. With
regard to a request for such information by the parent, it was agreed
upon "that a ten-day deadline would be more appropriate" than the
previous language that the agency should "comply with the request
without necessary delay." 34 CFR § 303.405. The new language
sets a very clear standard to ensure access to records for parents
who may potentially file for a due process hearing. Keep in mind,
the lead agency may be able to charge a fee for copies of records as
long as that fee does not "effectively prevent the parents from
exercising their right to inspect and review those records." 34 CFR
§ 303.406(c). A participating agency is now required to provide par-
ents a copy of each evaluation, assessment of the child and/or
family, and the IFSP "as soon as possible" after each IFSP meeting.
34 CFR § 303.409. Although many states already provided parents a
copy of these documents, it was not a Part C requirement until the
new regulations went into effect. The Department decided to add a
specific timeline for providing these documents following an IFSP.
As discussed above, if these documents are requested by the parent,
the lead agency is required to provide them within ten days of the
request. Without a request from the parent, the participating agency
has to provide such documents "as soon as possible."

Amending, Disclosing, & Destroying Records
- 34 CFR §§ 303.410-417

Parents who believe that information contained in their child's
early intervention records in inaccurate may request the participating
agency that maintains the information to amend it. 34 CFR §
303.410. With the new regulations, this provision applies not only
to the child being served, but also to any information about the par-
ents that they feel is inaccurate. If the participating agency refuses
to make any amendments to the information, the parents continue to
have the opportunity to request a hearing on the issue. 34 CFR
§ 303.411. The 2011 regulations emphasize that a parent may request
the hearing under the procedures laid out in 34 CFR § 303.410(d)
(1), or may elect to use the State's procedures at 34 CFR § 303.413
(i.e., procedures that are consistent with FERPA hearing require-
ments in 34 CFR § 99.22).

The "consent prior to disclosure or use" regulations now include
references to the specific exceptions to parental consent found in
both Part C and FERPA. 34 CFR 303.414. In certain situations,
a parent may not object to the lead agency providing documents in
the child's record to a third party, but the lead agency may still lack
the authority to do so regardless of parental consent due to certain
exceptions. By including the exceptions directly in the regulation,
it leaves little room for a lead agency to assume whether it has the
authority to disclose identifiable information to a third party.

The Department also noted that the regulation governing de-
struction of information now has references to GEPA and EDGAR
recordkeeping provisions that apply to Part C documentation. 34

CFR § 303.416. The lead agency is responsible for ensuring all
policies and procedures are met, including information on sanctions
and the right to file a complaint. 34 CFR § 303.417.

Parental Consent and Ability to Decline
Services - 34 CFR § 303.420

The Department clarified that parental consent is required for all
evaluations, including the initial evaluation to determine whether an
infant or toddler is eligible for Part C. This section also clarified
that parental consent must be obtained prior to the use of public
benefits or insurance, or private insurance, for items related to the
infant's or toddler's participation in the Part C program. 34 CFR
§ 303.420(a)(4). If a parent does not consent to evaluations, the lead
agency cannot use the due process hearing procedure in Part C or
Part B to challenge the parent's refusal. The Department com-
mented that "participation of infants and toddlers in the Part C pro-
gram is voluntary and a parent may refuse an initial evaluation or
assessment." 34 CFR § 303.420(c).

Surrogate Parents - 34 CFR § 303.422

There are two major changes to the surrogate parent regulations.
First, a surrogate parent cannot be an employee of the lead agency
or any other public agency or EIS provider that provides early inter-
vention services to the child or any family member of the child. 34
CFR § 303.422(d)(2)(i). Second, the lead agency must make
"reasonable efforts" to ensure the assignment of a surrogate not
more than 30 days after a public agency determines that the child
needs one. 34 CFR § 303.422(g). This timeline is consistent with
the timeline established within the Part B program.

Minimum State Complaint Procedures
- 34 CFR § 303.433

No major changes were made to the minimum state complaint
procedures. The Department wished to clarify that the time exten-
sion authorized for implementation of a final decision is allowed
only if exceptional circumstances exist or the parent and public
agency agree to extend the time in order to engage in mediation.
Keep in mind, the lead agency determines when there are excep-
tional circumstances with respect to a particular complaint that
would justify an extension of the 60-day time limit for completing a
complaint. 34 CFR § 303.433(b)(1)-(ii).

Filing a Complaint - 34 CFR § 303.434

The regulations now require all state complaints to be filed
within one year following the alleged violation. Previously, there
were specific instances where one could file a state complaint more
than a year after the violation. 34 CFR § 303.434(c). The Depart-
ment stated, "Limiting a State complaint to an allegation of a viola-
tion that occurred not more than one year prior to the date the
lead agency received the complaint will ensure that problems regard-
ing a State's Part C program are raised and addressed promptly." The
party filing the complaint must now forward a copy of the com-
plain to the public agency or EIS provider serving the child at the
same time the party files the complaint with the lead agency. 34
CFR § 303.434(d). This is to assist the public agency or EIS in
being informed of the issue and provide them with an opportunity
to resolve the disputes directly at the earliest possible time.

Convenience of Hearings and Timelines
- 34 CFR § 303.437

The Department acknowledged circumstances may exist that
should allow a hearing officer the ability to extend the 30-day time-

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Pooled Trusts

by Thomas E. Simmons*

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In March, April, and June of this year, three important court decisions resulted in a negative impact for pooled trusts serving older individuals with disabilities throughout the country. The first case, In re Pooled Advocate Trust, Inc., was decided by the South Dakota Supreme Court. The second case, Center for Special Needs Trusts, Inc., v. Olson, was decided by the Eighth Circuit Court of Appeals, originating out of North Dakota. The third case, Lewis v. Alexander, decided by the Third Circuit Court of Appeals, originated out of Pennsylvania. All three courts concluded that Medicaid eligibility penalties could be assessed against disabled individuals funding a pooled trust if the individual was age 65 or older at the time of funding the trust.

Pooled trusts are creatures of state and federal law, and the specific requirements for establishing a pooled trust are set forth in state administrative rules and federal Medicaid statutes. Medicaid was enacted by Congress and signed by President Lyndon Johnson as part of Title XIX of the Social Security Act. Medicaid is a cooperative federal-state program designed to provide medical treatment and long-term care services for needy persons. States electing to participate in the Medicaid program must develop Medicaid plans consistent with the federal Medicaid statute, regulations, and administrative rules. As a condition of receipt of federal Medicaid funds, a state plan must comply with federal laws and regulations.

Medicaid is thus a creature of federal law, administered on a state-by-state basis. Because Medicaid is a needs-based program, eligibility is governed, in part, by whether the individual is sufficiently financially impoverished. Eligibility is “means tested” and applicants must satisfy both resource and income limitation rules before eligibility is granted in South Dakota. In the South Dakota Department of Social Services (“DSS”). A single person receives long-term care Medicaid eligibility when his or her countable resources do not exceed $2,000 in value and his or her income is less than stated maximum monthly amounts. There are other eligibility requirements as well, such as residency.

States that voluntarily elect to participate in the Medicaid program (and all 50 States do, including South Dakota) must comply with the eligibility requirements set by Congress. Accordingly, in South Dakota, DSS must comply with Congress’ eligibility requirements. In the In re Pooled Trust appeal, DSS suggested that as the rule-maker, it has unfettered discretion to determine when eligibility for Medicaid applicants should be granted and when it should be denied — even to the extent of ignoring all of the trust rules entirely. Eligibility requirements established by states which elect to participate in the Medicaid program may be more liberal than those set by Congress, but not more restrictive. Any attempts by states or Medicaid Agencies to be more restrictive are preempted by federal law.

The long-term care Medicaid rules consider an individual’s gifts or “distributions” for less than fair market value and how such transfers impact eligibility for the program. The distribution rules contain the practice of becoming impoverished by aggressively conveying valuable assets to one’s heirs, then applying for Medicaid benefits. Distributions occurring within a 60-month “look-back” period result in a “transfer penalty,” meaning a period of Medicaid ineligibility, the larger the gift, the longer the penalty period.

The “Medicaid Divestment Penalty Divisor” is the number used to calculate the length of a Medicaid ineligibility period when a gift occurred within the 60 months prior to the date of a Medicaid application. In 2012, this number is $5,204. For every $5,204 in gifts, a penalty period of one month is imposed. For example, if a Medicaid applicant made gifts totaling $20,800 to her five adult children three years before applying for Medicaid, a four-month period of Medicaid ineligibility would be imposed, running from the date the individual would have otherwise been Medicaid eligible.

Trusts are also discussed in the Medicaid rules. The Medicaid program generally deems trust assets to be resources fully available to the beneficiary where the grantor has retained any beneficial rights over funds conveyed to a trust. When an irrevocable trust “contains any provisions under which payment from the trust may be made to or for the benefit of the individual, the entire portion of the principal or income on the principal from which payment to the individual could be made is considered a resource.” There are no transfer penalties for conveying assets to a trust for one’s own benefit, but there are penalties for conveying assets to a trust for a third party’s benefit unless the transfer falls within narrow exceptions discussed below (e.g., transfers to a trust for a disabled child).

Thus, the general rule is that where the grantor has retained beneficial rights, the trust assets are considered resources available to the beneficiary to the fullest possible extent that the Trustee’s discretion could be exercised. But, there are three limited exceptions. For three specific types of trusts, the deemed resource availability rules of self-settled trusts are suspended. The three types of trusts are “(d)(4)(A)” trusts, “(d)(4)(B)” trusts and “(d)(4)(C)” trusts. These trusts were first recognized by the Omnibus Budget Reconciliation Act of 1993 (commonly known as OBRA ’93).

A “(d)(4)(A)” trust is only available to individuals under the age of sixty-five (65) who are disabled. These are commonly referred to as “payback” or “under 65” trusts. To qualify as a “(d)(4)(A)” trust, the State Medicaid Agency must receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual. This is commonly known as a “payback” requirement. A payback trust can only be funded by individuals with disabilities age 64 or younger.

A “(d)(4)(B)” trust may be composed of only pension, Social Security, and other income to the individual. These trusts are referred to as “Medicaid Income Trusts” or “Miller Trusts.” Such trusts also contain a payback provision and have limited application because they cannot contain any assets, only income interests.

A “(d)(4)(C)” or “pooled” trust (sometimes referred to as a “C” trust) can only be established for the benefit of an individual who is disabled and must meet the following conditions:

(i) It is established and managed by a nonprofit association;
(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts;
(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined by section 1392c(a)(3))

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by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court; and

(iv) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

There is no "under 65" requirement with pooled trusts as there is with a (d)(4)(A) trust. However, the InRe Pooled Advocate Trust: Olson, and Lewis, courts concluded that individuals age 65 and older funding a pooled trust could be assessed a Medicaid divestment penalty, just as if they had made an uncompensated transfer to a friend or family member in order to accelerate Medicaid eligibility. The assets within the trust, however, remain excludable assets for Medicaid purposes since the individual has parted with ownership of assets conveyed to the trust.

Nonprofit organizations serving adults with disabilities created pooled trust programs as a way to supplement the individuals' future financial needs. Many of these programs were founded in the 1970s and 1980s. Pooled trust programs lower costs and minimum balances by pooling many irreversable trust accounts for investment and management purposes. Pooled trust accounts may be funded with the disabled beneficiary's assets; often coming from court awards and settlements or unexpected inheritances.

To conform with state and federal rules, investments of a pooled trust are pooled, but a separate "Sub-Account" is maintained for each beneficiary. Because of this requirement, a single master trust document is shared by all beneficiaries. All beneficiaries must qualify as disabled. The Pooled Advocate Trust, Inc. (PATI) trust itself is restricted to disabled individuals who are South Dakota residents. Persons who may establish a pooled trust are limited to the disabled individual, a court, or the individual's parent, grandparent or guardian. Thus, if the grantor lacks capacity, a court may confirm and establish the trust and approve its funding. A pooled trust is typically funded with the individuals' own funds as first party trusts.

The (d)(4)(A), (d)(4)(B) and (d)(4)(C) trusts balance the interests of the beneficiary with those of the state with various "payback" requirements and other specific mandatory provisions. These three limited exceptions recognize that public assistance programs like Medicaid do not and cannot meet all the needs of individuals with disabilities, and that trusts which meet the narrow requirements set by Congress should be non-countable resources in order to supplement individuals' needs.

The payback requirement in a pooled trust is qualified. It can be avoided entirely, so long as a deceased beneficiary's trust account is retained by the trust. Distributions to heirs or surviving family members can be made only if the Medicaid agency is repaid in full. In the PATI Trust agreement, the trustee is required to retain all assets in trust for the benefit of other trust beneficiaries if the beneficiary's trust assets are insufficient to repay the Medicaid lien in full. In this situation, a living beneficiary's Sub-Account will receive additional funds by virtue of a deceased beneficiary's Medicaid lien exceeding their remaining Sub-Account balance at the time of death. If the lien can be repaid from the beneficiary's trust account, however, then the Trustee is directed to do this and distribute the remainder to the beneficiary's heirs. The heirs are identified in the joinder agreement completed by the beneficiary or his or her guardian when the trust is initially funded. If the disabled benefici-

ary never incurred a Medicaid lien, no payback is required and all trust assets can be distributed at death to the beneficiary's heirs.

Third party trusts are those funded with a third party's assets (e.g., parents place assets in trust for their child with a disability). The rules for third-party trusts are quite different than for the first-party trusts. Most importantly, third-party trusts need not contain a payback provision. Thus, if one funds a trust for the benefit of a disabled nephew, any assets remaining in the trust at the nephew's death can be distributed to the nephew's siblings without first satisfying a Medicaid lien.

The InRe Pooled Advocate Trust case involved a pooled trust first created in 2004 by Pooled Advocate Trust, Inc. ("PATI"). a tax exempt 501(c)(3) organization. First Premier Bank serves as the trust's custodian. PATI's pooled trust pool was modeled after others established throughout the country. DSS adopted a policy in 2009 that would treat contributions to the PATI trust as divestments triggering a period of ineligibility if the contributions were made when the disabled individual was age 65 or older. PATI obtained a favorable ruling from Seventh Circuit Court Judge Davis, but DSS appealed.

While the appeal was pending before the South Dakota Supreme Court, two trust beneficiaries (Fred and Gladys Matthews) who had funded Sub-Accounts with the PATI Trust worked their way through the appeal process and eventually had their case consolidated with the PATI case. While the case was pending before the South Dakota Supreme Court, DSS amended its administrative rules to specifically impose divestment penalties for over-65 pooled trust beneficiaries. The Court ultimately decided in favor of DSS and confirmed the over-65 pooled trust divestment penalties rule.

In Olson, the Court first found the nonprofit organization that brought the case had standing to do so in a § 1983 action. This was a favorable ruling, as the Eighth Circuit Court rejected the reasoning in a 2009 Ninth Circuit case that concluded Medicaid eligibility rights could not be asserted in a § 1983 action. However, the Court found a 2008 letter from CMS to be persuasive authority and sided with the North Dakota Medicaid Agency. The Court said:

By the omission of an age requirement in [d)(4)(C) trusts], Congress' intent was to permit disabled persons over age 65 to participate in "C" pooled trusts. In fact, the parties agree that disabled individuals over age 65 can participate in a type "C" pooled trust. North Dakota, however . . . distinguishes a temporary disqualifications from participation in a pooled trust. The court thus approved North Dakota's over-65 pooled trust divestment penalties rule.

In Lewis, the court also concluded, consistent with the first two cases to weigh in on the question, that transfers to a pooled trust when the individual is age 65 or older will result in a specific period of Medicaid ineligibility. The Court concluded that certain aspects of Pennsylvania Medicaid law had to be set aside, including a "50% repayment retention provision." The provision required pooled trusts to provide that no more than half of the funds remaining in the beneficiary's Sub-Account could be retained in trust at death, with the remainder subject to a mandatory payback to the State. The Third Circuit ruled this restriction was preempted by federal law. Other than the over-65 aspect of the Lewis Court's opinion, the decision is largely favorable for disability rights advocates.

In view of these decisions, is there still a place for pooled trusts for individuals age 65 and older? Although the funding of a pooled trust for oneself or one's spouse as beneficiary will trigger a divestment penalty for long-term care Medicaid benefits, there are still

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two scenarios where individuals concerned with the prospect of devastating long-term care costs could legally utilize a pooled trust, accelerate Medicaid eligibility, and achieve a measure of asset protection and professional fiduciary management of trust investments. In fact, DSS’s Supreme Court Reply Brief in In re Pooled Advocate Trust acknowledged the proper planning opportunities available for protecting an individual’s assets, yet qualifying for Medicaid even though the individual might be age 65 or older.

[The pooled trust remains an appropriate option for individuals under the age of 65 as well as those age 65 and older. There is no prohibition against a disabled or elderly individual adding to a pooled trust in which they are a named beneficiary up to age 65. Thereafter, a person may no longer contribute funds to the pooled trust without incurring a transfer penalty, but may continue to benefit from the trust while maintaining Medicaid eligibility. The Department’s interpretation of this statute does nothing to nullify the statute or any benefit a disabled or elderly individual may receive from utilizing a pooled trust.

In the first scenario, a disabled over-65 individual could fund a pooled trust and wait at least 60 months prior to making a Medicaid application. So long as the beneficiary avoids submitting a Medicaid application until 60 months after he or she funded a pooled trust, the trust contribution will not result in any adverse Medicaid eligibility consequences. During and after the 60-month period, the Trustee may make discretionary distributions for the beneficiary’s benefit, even paying for long-term care expenses if there is not an available public benefit or insurance option to pay for those costs.

In the second scenario, an individual with a disability age 65 or older could consider a pooled trust where it is unlikely he/she could wait out the 60-month look-back period before applying for Medicaid. Here, instead of waiting 60 months, the individual intentionally triggers the divestment penalty by applying for Medicaid immediately after funding the trust. A formula could be utilized:

\[ D > C + I \]

where:
\[ D \] = Individual’s monthly income (social security, pension, etc.)
\[ C \] = Individual’s monthly expenses (care costs, etc.)
\[ I \] = the Medicaid Divestment Penalty Divisor ($5,204 in 2012)

Stated another way, if the Divestment Penalty Divisor is greater than the monthly care costs less the individual’s monthly income, an older individual may benefit from funding a pooled trust.

For example, assume Betty Jo, age 75, suffers from dementia. She is a widow with $80,000 in assets and $2,000 in monthly income from Social Security and a teacher’s pension. She recently entered a nursing home costing $6,000/month. If she does nothing, she will spend down her assets and qualify for Medicaid in about 20 months, leaving her with only $2,000 in assets. Betty Jo could benefit from funding a pooled trust because the Medicaid Divestment Penalty Divisor is greater than her care costs less her income: $5,204 > $6,000 - $2,000 = $5,204 is greater than $4,000.

What happens if Betty Jo transferred all but $2,000 to a pooled trust, then applied for Medicaid long-term care assistance? DSS would apply a divestment penalty period of approximately 15 months. During those 15 months, a simple (d)(4)(B) “Miller Trust” could funnel her $2,000 monthly income to her care costs, and the Trustee could pay Betty Jo’s remaining $4,000 in nursing home bills from her trust Sub-Account. At the end of 15 months, the Trustee would have distributed about $60,000 to pay for nursing home bills, leaving $20,000 in her trust Sub-Account. At that point, the divestment period expires and Betty Jo would qualify for Medicaid. The Trustee could use the remaining $20,000 to supplement her care needs, get her weekly massages or beauty parlor services, engage a care manager to advocate for her best interests, and make her nursing home stay more dignified. If she is on Medicaid for a relatively short period before she passes away, there will still be funds to distribute to her heirs. Otherwise, the funds will be retained in the trust and distributed to other pooled trust beneficiaries. As the South Dakota Supreme Court stated in In re Pooled Advocate Trust:

DSS’ policy does not deny a pooled trust beneficiary Medicaid assistance. The policy merely imposes a mandatory penalty period during which time the applicant is not eligible for long-term care assistance. The applicant may nevertheless qualify for medical-only coverage during the penalty period (as Gladys [Matthews]) did, and after the penalty period expires, the applicant may thereafter be eligible for long-term care assistance.

It is also possible that Betty Jo would pass away, say, six months after funding a pooled trust. In that case, the entire trust balance (except for about $24,000 for six months of care costs) would be distributed to her heirs. There would be no payback of Medicaid benefits since she never became Medicaid eligible.

Thus, there may be circumstances where money is preserved both for Betty Jo’s supplemental needs and for her heirs. Someone like Betty Jo is really no worse off than they would have been if she had done nothing. This is because Medicaid eligibility will be achieved with funds still remaining in the beneficiary’s Sub-Account at the expiration of the penalty period if planning is done correctly and costs are accurately projected.

It should also be noted that disabled individuals who are not yet 65 years of age could fund a pooled trust with no divestment penalty or 60-month waiting period. For individuals with disabilities under the age of 65, a pooled trust can result in immediate Medicaid and SSI eligibility because no divestment penalty can be applied. While elder law attorneys across the country see the three recent court decisions as unfortunate and contrary to a closer reading of federal Medicaid rules, disability rights advocates should be aware that appropriate and acceptable planning is still available with pooled trusts, even if the individual is over age 65 when funding the trust.

The author wishes to thank respected South Dakota/Illinois elder law attorney Kristi Vori (who represented the Matthews in the PATI appeal) for her assistance and editorial suggestions.

1 In re Pooled Advocate Trust, Inc., 2012 SD 24. In the interests of full disclosure, your author represented Pooled Advocate Trust, Inc. (PATI) and argued the In re Pooled Advocate Trust case before the Honorable Jefferson Davis, Circuit Court Judge, and later the South Dakota Supreme Court. Your author also founded PATI and drafted the PATI trust agreement. See pooledadvocatetrustinc.com.

2 Center for Special Needs Trust Administration, Inc. v. Olson, 17 F.3d ___ (8th Cir. 1994).

3 Lewis v. Alexander, 17 F.3d ___ (3rd Cir. 2012).

4 42 U.S.C. § 1396a at seq.

5 TLC Home Health Care, LLC v. Iowa Dep’t of Human Services, 638 N.W.2d 708, 712 (Iowa 2002) (citation omitted).


7 See Sioux Valley Hospital Ass’n v. Lake County, 553 N.W.2d 161 (S.D. 1997).

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line for scheduling a hearing and preparing a decision (availability of witnesses, pending evaluations, exceptional family circumstances, etc.). Therefore, the new regulations allow the hearing officer the discretion to grant a specific extension of time beyond the 30-day timeframe. 34 CFR § 303.437(c).

Due Process Complaint — 34 CFR § 303.441

The notice of the due process complaint, information necessary to be included in the complaint, the lead agency’s response to the complaint, and the resolution meeting regulations remain unaltered. The due process complaint must still include the following information: (1) The name of the child; (2) The address of the residence of the child; (3) The name of the EIS provider serving the child; (4) In the case of a homeless child, available contact information for the child, and the name of the EIS provider serving the child; (5) A description of the nature of the problem of the child relating to the proposed or refused initiation or change, including facts relating to the problem; and (6) A proposed resolution of the problem to the extent known and available to the party at the time. 34 CFR § 303.441(b)(1)-(6). The party receiving the due process complaint must, within 10 days of receiving the due process complaint, send to the other party a response that specifically addresses the issues raised in the due process complaint. 34 CFR § 303.441(f).

Resolution Meeting — 34 CFR § 303.442

Within 15 days of receiving the notice of the parent’s due process complaint, and prior to the initiation of the due process hearing timeline, the lead agency must convene a resolution meeting. 34 CFR § 303.442(a)(1). The purpose of this meeting is for the parent and lead agency to discuss the due process complaint and potentially resolve the complaint without the need for a hearing. 34 CFR § 303.442(a)(2). The meeting does not have to happen if both parties agree to waive the resolution meeting or if they agree to use mediation. 34 CFR § 303.442(3)(i)-(ii).

The parties have 30 days following the filing of a complaint to resolve the issue. If, after those 30 days, the complaint has not been resolved, the due process hearing may occur. 34 CFR § 303.442(b)(1). If the lead agency has been unable to get a parent to attend a resolution meeting, after the 30-day timeline has run, the lead agency may request that the hearing officer dismiss the complaint. If the lead agency has not scheduled a resolution meeting within the 15-day timeframe following the filing of the due process complaint, the parent may request to begin the due process hearing timeline. 34 CFR § 303.442(b)(3). A parent, lead agency, or EIS must request a hearing within two years from the date the parent, lead agency, or EIS knew or should have known about the alleged action which was the basis for the due process complaint. 34 CFR § 303.443(c).

Hearing Rights — 34 CFR § 303.444

All hearing rights guaranteed in the 2004 amendments are mirrored in the 2011 regulations. Any party to a hearing has the right to: (1) Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to the problems of infants or toddlers with disabilities; (2) Present evidence and confront, cross-examine, and compel the attendance of witnesses; (3) Prohibit the introduction of any evidence at the hearing that has not been disclosed to that party at least five business days before the hearing; (4) Obtain a written or, at the option of the parents, electronic, verbatim record of the hearing; and (5) Obtain written or, at the option of the parents, electronic findings of fact and decisions.

ACRONYMS USED IN THIS ARTICLE

IFSP — Individual Family Service Plan
LEA — Local Educational Agency
SEA — State Educational Agency
FERPA — Family Educational Rights and Privacy Act
IDEA — Individuals with Disabilities Education Act
EIS — Early Intervention System
GELP — General Education Provisions Act
EDGAR — Educ. Dept. General Administrative Regulations
CFR — Code of Federal Regulations

34 CFR § 303.444(a)(1)-(5). Parents should receive a copy of the hearing record and the facts and decision at no cost. 34 CFR § 303.444(c)(2).

As mentioned previously, this article covers only the procedural safeguards section of Part C of IDEA. There were a variety of changes made to other sections of the regulations and parents should become familiar with those sections of Part C as well. Other major areas of change include, but not limited to:

- Transition requirements;
- Natural environment provisions;
- IFSP content, including the “early intervention services” and “other services” components;
- Financial responsibility, systems of payment and ability to pay, as well as to the use of public benefits, insurance, and private insurance; and
- Provisions related to monitoring, enforcement, reporting, and allocation.

If you have questions on Part C services or the changes to Part C, please contact South Dakota Advocacy Services. You may also contact the SD lead agency, Birth to 3 Connections, at 400 Governor’s Drive, Pierre SD 57501, 605-773-3678, or 800-305-3064.

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ixix Hobbs v. Zenderman, 579 F.3d 1171 (10th Cir. 2009).
Eligibility for Long-term Care Under the South Dakota Medicaid Program

by Chris C. Houlette

The South Dakota Medicaid program provides coverage for long-term care for eligible individuals. Who are persons eligible to receive long-term care services under the Medicaid program? Administrative Rules of South Dakota ("ARSID") 67:46:03:02 provides that "[f]or long-term care assistance shall be provided to an eligible aged, blind, or disabled applicant or recipient, meeting one of the following:

1) The individual is at least 65 years of age at the time of application;
2) The individual has a central visual acuity of 20/200 or less in the better eye with the use of a correcting lens;
3) The individual has limited vision: the widest diameter of the visual field subtends an angle no greater than 20 degrees;
4) The individual is unable to engage in substantial gainful activity because of a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months; or
5) The individual is a child under 18 years of age who is unable to engage in substantial gainful activity because of a mental or physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months.

ARSD 67:46:03:03 allows for the SD Department of Social Services to approve long-term care assistance or medical services for an eligible person who meets any of the following requirements:
1) A licensed hospital, nursing facility, intermediate care facility, or assisted living facility that has a Medicaid provider agreement with the department for the level of care and services provided; or
2) An adult foster care facility licensed by the South Dakota Department of Health.

Per ARSD 67:46:03:18, disability is determined by the "disability/incapacity team," using the Supplemental Security Income (SSI) program guidelines found at 42 U.S.C. §§ 1382a(a)(2)(A) to 1382a(a)(2)(C), inclusive, as of January 1, 1995, based on medical evidence supplemented by a social history. It also provides that a person who receives "social security or SSI disability benefits meets the long-term care assistance disability requirements." ARSD 67:46:03:19 provides that an ophthalmologist is to determine blindness and if the disability requires long-term care. Also, if a person is receiving social security disability benefits or SSI benefits based on blindness, the person is considered to meet the blindness requirements for long-term care assistance.

According to ARSD 67:46:03:21, a person’s disability ceases and is therefore ineligible for long-term care assistance when either of the following occurs:
1) The disability/incapacity consultation team ... determines that a disability ceases to exist; or
2) The individual has been denied social security or SSI disability benefits based on a disability.

Furthermore, according to ARSD 67:46:03:20, a person’s eligibility for long-term care based on blindness ceases when either of the following occurs:
1) The individual has applied for and has been denied social security disability or SSI benefits based on blindness; or
2) The department has determined that the blindness does not require long-term care.

Eligibility for long-term care cannot be presumed and is subject to the requirements set forth by law. The determination whether there is eligibility is made on a case-by-case basis.

A Parent’s Checklist for Special Education Evaluations

by Gail C. Eichstadt

South Dakota school districts are required to identify children with disabilities living within their boundaries from birth to age twenty-one. (ARSID 22:5:22:01) Each district must develop a plan to accomplish this task. (ARSID 22:5:22:01) Parents who suspect their child, regardless of the child’s age, may need special education services may request an evaluation from their local school district. (ARSID 24:05:24:01) Parents can give their school’s principal, superintendent, or special education director a dated written request for an evaluation for their child. (ARSID 24:05:24:01)

If parents disagree, they may file for a due process hearing. (ARSID 24:05:30:07:01)

South Dakota Special Education Programs staff recognized a need to revise the state’s prior notice and meeting notice forms relating to special education evaluations. Lisa Sanderson of South Dakota Parent Connection and Gail C. Eichstadt of South Dakota Advocacy Services represented these agencies’ and parents’ concerns at the “Special Education Programs Workgroup for Prior Notice and Special Education State Forms Revision” in February and May 2012. Special education directors, school psychologists, special education teachers, and education cooperative staff also comprised the workgroup. As part of the group’s work, Lisa and Gail developed a checklist for parents to use in identifying concerns that may lead to a special education evaluation. The checklist is found at www.sped.org (How We Help/Resources tabs). Parents are encouraged to review the list, printed on the following page, if they have concerns about their child.
A Checklist for Evaluation Requests

South Dakota Advocacy Services and South Dakota Parent Connection developed a checklist for parents and educators to use when requesting an evaluation. This checklist will help identify areas of concern and/or reasons for a referral.

**Language Arts**
- Vocabulary - spoken
- Recognizes letters of the alphabet
- Knows sounds of letters of the alphabet
- Recognizes words
- Vocabulary - reading
- Understands what he/she reads
- Reading speed and accuracy
- Expressing thoughts in writing
- Spelling/punctuation
- Sentence/paragraph structure
- Difficulty listening
- Other

**Numbers/Mathematics**
- Telling time
- Counting money
- Measuring
- Basic math facts
- Calculations
- Word problems
- Geometry
- Problem-solving
- Measurement
- Probability/data
- Analysis
- Math reasoning
- Other

**Behavior/Social**
- Noncompliance
- Lack of motivation
- Self-concept/esteem
- Peer relationships
- Adult relationships
- Changes in relationships with family/friends
- Withdrawn/moody
- Overactive/underactive
- Isolates self
- Irrational fears
- Verbally aggressive
- Physically aggressive
- Fearful/anxious
- Repetitive behaviors
- Difficulty adjusting to change in routine
- Limited interests and activities
- Unusual interests
- Obsessive interests or behaviors
- Emotionally unstable
- Difficulty sleeping
- Decreased energy
- Irritable
- Easily distracted
- Self-destructive
- Overly sensitive/cries easily
- Poor social boundaries
- Unusual response to typical stimuli
- Bullied by others
- Bullies others
- Seeks attention in inappropriate ways
- Unaware of dangers
- Sexualized behaviors
- Other

**Motor (Muscle) Skills**
- Copying
- Handwriting
- Walking/running
- Throwing/catching
- Fine Motor (hands/fingers) coordination
- Gross motor (arms/legs/trunk) coordination
- Moving from sitting to standing
- Moving from sitting to standing
- Transitioning from class to class
- Frequent falls
- Balance/reflexes
- Concerns with child safety
- Comorbid behavior
- Walks on tiptoes
- Unusual hand movements/posturing
- Other

**Health/Medical**
- Problems with vision
- Problems with hearing
- Concussion or traumatic brain injury
- Loss of consciousness
- Seizure
- Stroke
- Headaches
- Dizziness
- Diagnosed congenital disease
- Overweight/underweight
- Fatigued/listless
- Frequently gets hurt
- Diagnosed medical condition
- Medication
- Physical complaints
- Diagnosed mental health condition
- Other

**Communication**
- Difficulty expressing what he/she wants to say
- Difficulty understanding what he/she hears
- Difficulty repeating what is said
- Uses gestures instead of words
- Appears to not hear what is said
- Loss of acquired vocabulary
- Limited vocabulary
- Student speech difficult to understand
- Student non-verbal
- Other

**Study/Work Skills**
- Disorganized
- Making transitions
- Avoids difficult tasks
- Poor work habits
- Abstract thinking difficulties
- Poor judgment
- Following directions
- Starting tasks
- Completing tasks
- Does not work independently
- Remaining seated
- Concentration/attention span
- Excessive daydreaming
- Turning in assignments
- Difficulty with memory
- Other

**Daily Living Skills**
- Toileting
- Dressing self
- Feeding self
- Drinking from cup
- Communicating basic wants/needs
- Safety (self or others)
- Understanding/responding to social cues
- Cullible/naïve
There were several other presenters at the conference. Janine Kern, Circuit Court Judge in the Seventh Judicial Circuit of South Dakota, presented “FASD and Its Impact on the Judicial System,” which detailed how people with FASD can become involved in the judicial system if they are not properly identified. Valborg Kvigne, M.B.A., a Researcher for the Center for Rural Health Improvement at Sanford School of Medicine, University of South Dakota, presented “Vocational Strategies for Adults” Jennifer Thomas, Ph.D., a Professor with the Department of Psychology at the Center for Behavioral Teratology at San Diego State University, presented “Strategies for the Intervention/Treatment for FASD.” Sarah Brown, MS OT/T/L, is the owner of Building Blocks Therapy, Inc. Brown presented “Sensory Processing and Behavior ... Are They Related?” This presentation consisted of detailing different senses and how FASD affects a person’s ability to block out and absorb stimuli. Brown also gave examples of different occupational therapy treatments. Nora Boesen, LPN, a parent of children with FASD, presented “A Mother’s Perspective: Bringing it Home.” In addition, Helen E. Usara, Ed. D., facilitated a round-table discussion regarding FASD. Usara is the President and CEO of the Chiesman Center for Democracy, Inc. She serves as the Project Director for the FASD Center.

Over 300 people attended the conference and it was a great success. A large group of parents, professionals, and caregivers all learned a great deal about FASD, taking away very important lessons. One of the main themes of the conference was that people with FASD often do not exhibit facial features associated with FASD, and that communities must learn the warning signs. Another was that children with FASD who have not been identified are likely to end up having “behavior” problems at school, being unemployed, becoming homeless, or even becoming dependent on illegal substances.

The literature participants received provided some startling data. FASD costs South Dakota 17.9 million dollars annually. FASD affects 1 in 100 live births. One in five women drinks alcohol while pregnant. In addition, the foundation has created an FASD South Dakota Directory of Services, which details options for people with FASD or parents of children with FASD.

Perhaps the most important lesson taken away from this conference is that ALL FASD cases are completely preventable. With better information and organizations like the FASD center, hopefully communities in South Dakota will become better informed of the dangers of drinking while pregnant and stop FASD from occurring. If you would like more information on FASD and how/where it is diagnosed, please visit the Chiesman Foundation for Democracy's website: www.chiesman.org.

SD Report — Formats Available
by Pam Middleton

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Partners in Policymaking —
Twenty Years Strong
by Sandy Stocklin Hook

The class of 2012 of South Dakota Partners in Policymaking marked the 20th class to graduate from the leadership, empowerment, and training program. On April 28, 2012, twenty-seven individuals from the class of 2012 joined over 450 graduates of South Dakota Partners in Policymaking to network and to promote systems change.

The class was comprised of self-advocates, parents, and family members of individuals with disabilities from all areas of South Dakota. Members included: Brent Adams, Mike Foster, Andrew Kremnitz and Fred Ray from Huron; Elmer Athey, Big Stone City; Matthew Athey, Milbank; Richard Bartling, Burke; Kristin Brandt, Revillo; D'Este Chytka, Lake Andes; JoAnne Cleveland, Rhonda Erickson and Adam ‘Pal’ Merchen of Spearfish; Carolyn Deal and Durrel Propst, Pierre; Joe Dvorak, Christoph Faundeen, Josh Nankivel, Anne Sullivan, and Jennifer Wilker-Brown of Sioux Falls; Joleen Garneau and Shannon Luke, Highmore; Charles Henrie and Jennifer Scott, Rapid City; Jennifer Jacobson, Salem; Caryl Johnson, Aberdeen; Stacy Lambrecht, Brandon, and Linda Muise, Vale. Congratulations to the Class of 2012!

Derrick Dufresne

These individuals were honored in Sioux Falls on April 28, 2012, for completing the innovative leadership program, Partners in Policymaking. Partners training analyzes developmental disability issues and builds skills that consumers, parents, and guardians need to effectively obtain the most appropriate state-of-the-art services for themselves and others and participate in decision-making situations.

Three hundred-fifteen people attended the banquet and commencement ceremonies at the Ramada Inn & Suites in Sioux Falls, including District 13 Representative Susy Blake of Sioux Falls, who received the 4th annual Legislative Advocacy Award, which is given by the Protection and Advocacy Developmental Disabilities (PADD) Advisory Council to a legislator who supports disability-related legislation. Unable to attend the festivities, but sending letters of congratulations, were Governor Dennis Daugaard, Senators Tim Johnson and John Thune, and Congressman Kristi Noem. Derrick Dufresne, a consultant from St. Louis, MO, was the keynote speaker and told the audience, “This isn’t about disability ... this is about citizenship and a sense of belonging. Seeing people work together for a common cause is very powerful.”

Judy Struck of Sioux Falls, Executive Director for the Center for Disabilities at Sanford School of Medicine at USD, received the 11th annual Robert J. Keen Advocacy award. This award, sponsored by the SD Advocacy Services’ Board of Directors, is given to an individual for exemplary advocacy on behalf of all individuals with disabilities.

Partners in Policymaking in South Dakota is conducted by South Dakota Advocacy Services (SDAS). “This year was a milestone for SD Partners in Policymaking. It was the 20th year of the training program in South Dakota and the national program celebrated 25 years!” noted Sandy Stocklin Hook, project coordinator for the statewide training course. “We now have over 478 individuals throughout our state who have completed Partners in Policymaking. Their voices are being heard!” She also commented, “We strongly believe that individuals who use services should have a major role in determining what services they are being provided and how they are delivered. It is really exciting to see the Partners’ enthusiasm and commitment to improving national, state and local services.”

Representative Susy Blake

While attending the six-month training program, the participants learned about the history of the disability movement, people first language, and how the legislature works, as well as city, county, school, and tribal government. Other topics included effective meetings, abuse & neglect, ADA, assistive technology, inclusive education, employment, and being a part of a community. The class noted one of the highlights of the training was meeting and visiting with the Governor, Lt. Governor, and several legislators, and providing mock testimony.

Judy Struck

Class graduation speakers included Chytka, Cleveland, Henrie, Jacobson, and Wilber-Brown. Each spoke from the heart about how Partners training has changed their lives. “We are now better advocates, friends, and mentors,” commented Henrie.

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Partners in Policymaking
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Cleveland spoke about the presenters and how they relate to the participants and their individual situations. As parents, Chytka, Jacobson, and Wilber-Brown all spoke that Partners led them to believe in having a dream for their child.

JoAnne Cleveland

In addition, 157 graduates from Years 1-19 spent the weekend in Sioux Falls attending continuing education classes on current issues. “Networking is a very integral part of the entire training initiative. We have made a commitment to gather all graduates with the current class. Once a Partner graduates they are not forgotten,” noted Stocklin Hook.

Continuing education started with a session on Bullying by Byron Utter of Mobridge. Utter talked about recognizing the lead bully. He said, “You see the person doing the talking and then behind him/her you see the ‘bobble heads’ just shaking their heads up and down and following along. The bobble heads are where you need to start ... take away the followers and the leader has no one to lead.” He spoke about bullying happening on the internet, chat rooms, social networks, and cell phones. He noted, “One text message has the potential to be distributed to 400 people!”

Other continuing education classes included: Zumba, instructed by Angie Albenico, Spearfish, a Year 19 graduate; Invisible Disabilities by Lisa Lynch-Carroll of Wagner, Year 18 graduate; and the South Dakota Council on Developmental Disabilities and Self-Advocates for Change by Sarah Carda, Year 12, of Yankton, along with Rick Rust, Year 19, and Mike Greinhs, Year 18, of Watertown, and Derrick Smith, Year 16, of Sioux Falls. Cary Gronemeyer, Year 12, Sioux Falls, presented on Internet safety. Dan Ahlers of Dell Rapids gave tips on resume writing, interviewing, and how to keep a job after you secure employment. SDAS Legal Director and 20-year Partners presenter, John Hamilton of Sioux Falls, discussed the parents' role in the IEP team and how to be a SUPERHERO for your child. Elinee Roberts, Executive Director of SD Parent Connection, facilitated a session for siblings who have a brother/sister with a disability or chronic health concern.

Year 12 graduate of Spearfish, Dillon Haug, outlined how he has learned to live a self-directed life and be involved in community. Congressional Staffers were available to listen to people and hear their concerns over federal legislation. Carmyn Egge and Jeannie Howland of Sioux Falls respectively represented Senators Tim Johnson and John Thune. Congresswoman Kristi Noem was represented by Brad Otten of Rapid City, a Year 18 graduate.

Dennis Hook of Pierre, 4th degree master in Tai Kwon Do, discussed and demonstrated self-defense and provided inclusive recreation tips for people of all abilities. Stacy Skaff of Sioux Falls helped participants understand the importance of good nutrition and making the right choice of what to eat.

Jennifer Wilber-Brown

Year 21 of SD Partners in Policymaking will begin in November 2012. For more information on the program, contact Sandy Stocklin Hook, SDAS, 221 S. Central Ave., Ste. 38, Pierre, SD 57501, or call 1-800-658-4782. You can visit the SDAS Website for Partners information at www.sdadvocacy.com or email hooks@sodadvocacy.com.

Partners in Policymaking in South Dakota is sponsored in part by grants from the South Dakota Council on Developmental Disabilities, Children’s Care Hospital and School, USD Center for Disabilities, and South Dakota Parent Connection, as well as the PADD, PAIR, and PAIMI Programs of SDAS.

Celebrating 20 Years of Partners in South Dakota

History of SD Partners in Policymaking
by Sandy Stocklin Hook

Partners in Policymaking originated in Minnesota through its Governor’s Council on Developmental Disabilities in 1987. Partners is an innovative leadership training program designed for adults with disabilities, family members, and parents of children with disabilities. The mission of the program is twofold: to learn best practices and expand personal competencies to meaningfully engage policymakers and fully participate in communities of choice.

Since 1987, Partners in Policymaking programs have been implemented in 46 states, the Northern Mariana Islands, Netherland Antilles, Virgin Islands, and the United Kingdom. However, since South Dakota began its Partners program in 1993, it has developed a style, philosophy, and dedication that is unique unto itself. South Dakota Partners graduates are part of SD Partners History (Continued on page 18)
Hyperbaric Oxygen Therapy
by Charlene Hay

Hyperbaric oxygen therapy (HBOT) is a medical treatment that enhances the body's natural healing process by inhalation of 100% oxygen in a total body chamber, wherein atmospheric pressure is increased and controlled. It is used for a wide variety of treatments usually as a part of an overall medical care plan.

Under normal circumstances, oxygen is transported throughout the body only by red blood cells. With HBOT, oxygen is dissolved into all of the body's fluids, the plasma, the central nervous system fluids, the lymph, and the bone and can be carried to areas where circulation is diminished or blocked. In this way, extra oxygen can reach all of the damaged tissues and the body can support its own healing process. The increased oxygen greatly enhances the ability of white blood cells to kill bacteria, reduces swelling, and allows new blood vessels to grow more rapidly into the affected areas. It is a simple, non-invasive and painless treatment.

HBOT dates back to 1950 when used for the treatment of blood disorders in animals. HBOT has been used by individuals sustaining burn injuries. Over the years, the scope of HBOT treatment has expanded and has been under study by the United States military for the treatment of TBI, PTSD, and Depression. Clinical Trials are being developed to determine the scope of HBOT's ability to provide relief and/or healing.

What Are The Benefits of HBOT?
- Assists in rehabilitation by stimulating production of the body's stem cells;
- Boosts immune system function;

HBOT Therapy
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SD Partners History
(Continued from page 17)

of a growing network of community leaders assisting others and serving on policymaking committees, commissions, and boards at all levels.

Partners resulted from a realization and need. In the early 1990s, South Dakota Advocacy Services realized that with limited resources, its efforts could not be in all places of the state at all times. It also knew that there was a critical need for training opportunities on the unique challenges of disabilities for adults with disabilities and their families. In 1992, a search was conducted and South Dakota Advocacy Services used the Partners in Policymaking model to secure a grant from the SD Council on Developmental Disabilities (SDCDD). From its first session with 18 participants, Partners began providing a sustainable resource throughout South Dakota to help participants resolve issues in their local communities and to advocate for themselves and others in many levels.

Colleen Fry coordinated the Partners training through Year Five. When she left SDAS, Nancy Schade and Sandy Stocklin Hook became co-coordinators for Year Six. Schade was the CAP Program Director and saw the natural fit of facilitating Partners in conjunction with her other duties. In Year Seven (1998-1999), Schade transitioned from Partners and Hook became the coordinator. Through Year Nine, Sandy and Partners received a lot of support and assistance from Robert Blachford, a Year One Partners graduate. Many remember Bob's dedication and his passing away in April 1999, and certainly his advice to "kick 5% with style!" Lori Douville, a Year Seven graduate, ably stepped into Blachford's shoes and has graciously volunteered her time to assist Stocklin Hook with the many responsibilities involved in the training since then. Tim Neyhart, SDAS PADD Program Director since 2000, is directly involved in Partners planning, implementation, and, together with other staff, presenting at Partners.

Throughout the years, the Partners training has evolved and grown to be recognized as one of the premier training events in South Dakota. The growth is also reflected in the divergent funding sources that contribute to the training. The higher level of funding allowed Partners to expand and train additional participants. In addition to the SDCDD, current contributors are Center for Disabilities of Sanford School of Medicine at the University of South Dakota, Children's Care Hospital and School, and South Dakota Parent Connection, as well as the PADD, PAIR, and PAIMI Programs of SDAS.

Four hundred and seventy-eight (478) individuals have completed Partners in Policymaking training and are changing their communities. They are active Partners - Partners with community organizations and agencies, Partners with federal, state, county and local governments, Partners with schools, Partners with employers, and most importantly, Partners with each other - They are Partners in Policymaking. The following is a class-by-class breakdown of graduates:

| Year One | 18 graduates |
| Year Two | 26 graduates |
| Year Three | 20 graduates |
| Year Four | 21 graduates |
| Year Five | 20 graduates |
| Year Six | 23 graduates |
| Year Seven | 24 graduates |
| Year Eight | 19 graduates |
| Year Nine | 26 graduates |
| Year Ten | 26 graduates |

Out-of-State transfers: 2

Partners in Policymaking Year 21
Application Deadline !!!

Applications for Year 21 of Partners in Policymaking are available at all SDAS offices, at the SDAS website, www.sdadvocacy.com, or by contacting Sandy Stocklin Hook at 800-658-4782 or hook@sdadvocacy.com.

Application Deadline is September 20, 2012
HBOT Therapy (Continued from page 18)

- Decreases swelling and inflammation;
- Delivers oxygen to tissues up to 25 times normal levels;
- Heals injuries faster;
- Helps the body to clear toxins;
- Increases the body's ability to fight infection;
- Promotes regeneration of injured tissues;
- Reduces fatigue from chronic hypoxia;
- Stimulates brain & nerve cells recovery from injury (hypoxic penumbra);
- Stimulates collagen production, speeding up the wound healing process; and
- Supports growth of new blood vessels.

Hyperoxygenation of tissues and body fluids is one of the most impressive benefits of HBOT. The true impact of HBOT is recognized after several individualized treatments. It is extremely effective in healing cerebral arterial gas embolism and decompression sickness (the Bends) - conditions common in scuba diving that may lead to death if left untreated.

HBOT may play a significant role in healing conditions such as Diabetic Ulcers, Peripheral Vascular Disease, and other conditions associated with compromised blood vessels. It helps to fight toxins and enhances therapeutic effects of antibiotics.

Insurance and Medicare may cover the following conditions calling for HBOT treatment:
- Air or Gas Embolism;
- Carbon Monoxide Poisoning;
- Compartment Syndrome/Crash Injury/Other Traumatic Ischemias;
- Decompression Sickness (Bends);
- Diabetic and Selected Wounds;
- Exceptional blood loss (Anemia);
- Gas Gangrene;
- Intracranial Abscess;
- Necrotizing Soft Tissue Damage;
- Radiation Tissue Damage;
- Osteomyelitis;
- Skin Grafts; and
- Thermal Burn.

The July 2011 issue of the South Dakota Report contained an article describing SD Medicaid's coverage of HBOT.

Dr. Paul G. Harch, of HBOT - Harch Hyperbarics, is a hyperbaric, diving, and emergency medicine physician who is also clinical assistant professor and past director of the Louisiana State University School of Medicine's Hyperbaric Medicine Fellowship Program. His research and publications in hyperbaric therapy are extensive. In 2007, he published the book, The Oxygen Revolution (described as "the first book to explain the revolutionary importance of this life-saving treatment option."). Author Paul G. Harch, M.D. brings to the controversy about HBOT, the evidence for various uses, and provides key information about pursuing treatment to patients and their families, allowing them to make an informed decision about their treatment.

Dr. Harch estimates use of HBOT for:
- Brain injury and stroke;
- Autism and other learning disabilities;
- Cerebral Palsy and birth injuries;
- Alzheimer's, Parkinson's, multiple sclerosis, and other degenerative neurological diseases.
- Emergency situations requiring resuscitation, such as cardiac arrest, carbon monoxide poisoning, or near drowning;
- Improving inflammatory conditions such as arthritis and asthma;
- Healing wounds, infections, and burns, and slowing the aging process.

Dr. Harch feels that HBOT can turn people's lives around. "Our brain controls all of our being, our intellectual function, our personality, our jobs, our relationships, our emotions - everything - and when people who have such dysfunction recover, it changes their lives in immeasurable ways."

He sees HBOT as revolutionizing medicine due to its many applications. "Cardiac arrest, surgical complications, dementia, traumatic brain injuries, residual effects of stroke, cerebral palsy, our personality, our jobs, our relationships, our emotions - everything - and when people who have such dysfunction recover, it changes their lives in immeasurable ways."

Agle Leaves SDAS

Christina ("Tina") Agle recently resigned her position as Advocacy Services Representative in our Rapid City Office to move to Alaska as a result of her husband's transfer from Ellsworth Air Force Base. Her final day of work was July 13, 2012.

Tina has worked at South Dakota Advocacy Services (SDAS) since March 3, 2008. During her four-plus years working at SDAS, Tina advocated for persons with disabilities in our PADD, CAP, PAIM, PAIR, PAAT, and PAVA Programs. In particular, she enjoyed working with her clients in pursuing their goals in a variety of situations and was known to be a clear and articulate spokesperson on their behalf.

SDAS will miss Tina's enthusiasm and energy. We wish her well in her future endeavors.
HBOT Therapy

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...the list of possible things treatable with hyperbaric technology goes on and on." Dr. Harch feels that HBOT can impact hundreds of thousands of brain-injured soldiers in our country alone, but worldwide, HBOT could change healthcare dramatically.

Dr. Harch finds that HBOT appears to be causing new tissue growth in the brain. It acts like a drug that unlocks and stimulates certain gene sequences in DNA, resulting in growth and repair.

In recent years, Dr. Harch has treated dozens of veterans using HBOT. He conducted a study of 15 PTS/TBI patients by administering a battery of tests before and after the treatments. They showed an average IQ improvement of nearly 15 points. Thirteen out of these 15 reported fewer headaches. Nine of the 12 who had insomnia before the treatments cited improved sleep. Seven of the 11 individuals on prescription medication for their conditions cut back on or quit the medications. Dr. Harch also used the military's PTS checklist to score subjects before and after treatments. They showed 30-percent reductions in their PTS scores after hyperbaric oxygen treatments.

"The purpose of this is to give them their lives back, give them back their families," Harch says. "We sent them off to war, and they allow me to sit here in my comfort and do what I'm doing and not worry about being blown up or worry about the security of my family. They put it all on the line, and they need to be rewarded for that. They deserve, at least, an attempt to get back some of that lost function. And that's what this can do."

Unfortunately, there is an outdated perception about the HBOT procedure; Dr. Harch admits physicians were taught that HBOT is a fraud. Over the past few years, physicians have come to understand the positive effects of HBOT.

There is much information on the web regarding HBOT. Clinical Trials are being administered not only in the military, but also in private institutions. This author feels that much more information will be forthcoming through the military and private medical institutions. We would be wrong if we do not explore HBOT and determine if this is a form of treatment that may help a family member or ourselves.

Much of the information in this article comes from Dr. Harch's website, www.hbot.com.