



16 July 2007

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Washington, D.C. 20202-2641

RE: IDEA – Part C Proposed Regulations

**Description of the Education Law Center
and the Juvenile Law Center**

The Education Law Center – PA (“ELC”) is a non-profit education advocacy organization that uses legal and other strategies to advocate on behalf of Pennsylvania’s most educationally “at risk” children. In our more than 30 years of operation, we have helped thousands of children with disabilities, including infants and toddlers, obtain appropriate special education and early intervention services, whenever possible together with their peers without disabilities.

Juvenile Law Center (“JLC”) is the oldest multi-issue public interest law firm for children in the United States. JLC uses the law to ensure that youth, particularly those in the child welfare and juvenile justice systems, receive fair and developmentally appropriate treatment. JLC gives special attention to issues of access to education, physical and behavioral health care, employment and housing.

ELC and JLC staff members have often worked with foster families, child welfare agencies, education agencies, and others to advocate for better educational opportunities for children in out-of-home care. In addition, ELC and JLC are members of the National Working Group on Foster Care and Education. The Working Group is a partnership of child advocacy organizations which, under the auspices of Casey Family Programs, have undertaken a national effort to promote educational stability and improved educational outcomes for children in foster care.

ELC and JLC are in frequent contact with other organizations and individuals from around the country, and we exchange with them information on effective strategies for improving educational outcomes for children and youth in out-of-home care. Our comments to the proposed Part C Regulations are based on our extensive experience in Pennsylvania with the educational needs and problems of children in the custody of child welfare, and our knowledge of national reform efforts.

Why Do Children in the Child Welfare System Need Special Protections in Part C?

Early intervention services provided under Part C of the IDEA are especially important to infants and toddlers in out-of-home care. Children in the child welfare system are more likely to need special education services, in part because they are more likely to have been exposed to a variety of negative experiences, including abuse and neglect, family violence, alcohol abuse, and dangerous levels of lead paint. These experiences and conditions often lead to developmental delays requiring special education services.¹ While it is estimated that between 30 and 40 percent of all children in out-of-home care receive special education services,² the risk of developmental delay is of particular concern for very young children. Infants are more likely to reenter foster care, and as a result experience recurrent disruption of family bonds and maltreatment. These experiences in turn lead to increased likelihood of behavior problems, developmental delays, and health problems.³

Because of these increased risks, early intervention services provided under Part C are critical to improving developmental and educational outcomes for children in the child welfare system. The special needs of this population were recognized by Congress when it amended IDEA Parts B and C in 2004 and included specific provisions for these children's protection.

Infants and toddlers in out-of-home care confront unique challenges which impede their access to and use of early intervention services. These challenges may include:

- Initial removal from the home and subsequent changes in caregivers. This absence of a consistent caregiver can result in a failure to identify infants and toddlers with developmental delays.
- Increased risk of experiencing delays due to abuse, neglect (including abandonment), or exposure to violence, alcohol abuse, or dangerous levels of lead paint.

¹ Sheryl Dicker, Elysa Gordon & Jane Knitzer, *Improving the Odds: Promoting Health, Developmental and Emotional Well-Being of Young Children in Foster Care*, National Center for Children in Poverty (2001).

² Summary: Improving Education for Homeless and Foster Children with Disabilities in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004) 1 (Children's Defense Fund, March 2005), available at www.childrensdefense.org/site/DocServer/idea_2004_summary.pdf?docID=558.

³ Judith Silver and Sheryl Dicker, *Mental Health Assessment of Infants in Foster Care* (in press, Journal for Child Welfare, 2007).

- Early intervention providers’ unfamiliarity with educational and developmental approaches designed to meet the specific needs of children who have experienced or have been exposed to abuse, neglect (including abandonment), or family violence.
- Confusion over who has decisionmaking authority for a child.
- Lack of communication between early intervention services providers and biological parents (even where those parents retain decisionmaking rights).
- Confusion over whether a surrogate parent is needed and who should serve in this capacity, resulting in a failure to promptly appoint an appropriate surrogate parent or other alternate decisionmaker.
- The absence of strong, stable advocates for infants and toddlers at risk.

Summary of Recommendations

Cognizant of these particular challenges, our comments to the Part C regulations seek to ensure that: (1) infants and toddlers in out-of-home care are identified and referred for early intervention services; (2) biological parents actively participate in the decisionmaking process to the greatest extent possible; (3) as necessary, children in foster and congregate care are represented by appropriate and effective alternate decisionmakers; (4) caregivers participate in the referral of children and the decisionmaking process and (5) children in out-of-home care receive early intervention services designed to address their unique needs as victims of abuse and neglect.

We propose specific changes to the proposed regulations to ensure that children in the child welfare system are identified, referred for screening, and provided with needed early intervention services. In summary, we propose:

(1) *Children In Out-of-Home Care Must Receive Prompt Access to Early Intervention Services.*

It is well documented that the provision of early intervention services results in improved academic success and significant social and behavioral gains for children.⁴ These gains are especially critical for children in foster and congregate care, many of whom remain in care throughout their early years.

In the United States, 513,000 children under the age of 18 are in the foster care system on any given day.⁵ These children are disproportionately young; about 30% of the children placed in foster care annually are younger than five.⁶ Infants constitute the largest portion of this group, with 20% of all admissions younger than 12 months.⁷ These children are more likely to experience medical problems and developmental delays, and are at heightened risk for negative

⁴ Sheryl Dicker & Elysa Gordon, *Building Bridges for Babies in Foster Care: The Babies Can’t Wait Initiative*, *Juvenile and Family Court Journal* (2004) at 30.

⁵ Scott Joftus, *Educating Children in Foster Care: The McKinney-Vento and No Child Left Behind Acts*, *Casey Family Programs* (2007) at 5.

⁶ *Improving the Odds*, 2 n.1 *supra* at 5.

⁷ *Building Bridges for Babies in Foster Care*, 3 n.4 *supra* at 29.

outcomes later in life. They are more likely to drop out of school, become pregnant as teenagers, and become homeless or incarcerated.⁸

National child welfare statistics indicate that nearly 30% of children in foster care remain in the child welfare system for more than three years.⁹ However, research discloses that often only a small percentage of foster care children utilize early intervention programs.¹⁰ One New York study surveyed biological and foster parents of children in the child welfare system. Eighty-nine percent of biological parents and fifty percent of foster parents surveyed stated they were unaware of, and had never been informed about, early intervention services.¹¹ In addition, many children in the child welfare system are not placed with foster parents; nearly 20% of the children in the child welfare system are currently living in a group home or institution.¹²

To ensure that all children in the child welfare system are identified and have prompt access to needed services, we propose that the U. S. Department of Education make the following changes:

- Restructure several provisions to ensure that all children in the child welfare system, including both children in foster care and in congregate care, are covered by the regulations. In short, we suggest including “children in foster care” whenever the regulations use the term “wards of the State.”
- Mandate referral for evaluation under the child find system of infants and toddlers who have been abandoned, are identified as being affected by alcohol abuse or prenatal alcohol exposure, or are identified as having been exposed to family violence or dangerous levels of lead paint. It is well documented both that all of these experiences greatly increase the risk of developmental and educational delays and that each of these experiences is more common for children in out-of-home care.
- Alternatively, if the Department does not adopt our request for mandatory referral of these children, specifically reference prenatal alcohol exposure, exposure to dangerous levels of lead paint, alcohol abuse, abandonment, and exposure to family violence in the definition of “at-risk infant or toddler” relating to discretionary referrals.
- Include a 10-day timeline for primary referrers to refer children under the child find system. The earlier children are identified and served the better the educational and developmental outcomes.

⁸ *Improving the Odds*, 2 n.1, *supra* at 5-7.

⁹ AFCARS Report #10: Preliminary 2003 Estimates as of April 2005, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *available at* www.acf.hhs.gov/programs/cb.Ibid.

¹⁰ *See, e.g., Building Bridges for Babies in Foster Care*, 3 n.4 *supra* at 29.

¹¹ Educational Neglect: The Delivery of Educational Services to Children in New York City's Foster Care System 4 (Advocates for Children of New York, Inc., 2000), *available at* <http://www.advocatesforchildren.org/pubs/2005/fostercare.pdf>.

¹² AFCARS Report #10, 4 n.9 *supra*.

- Require that children who have been screened but not referred for a comprehensive evaluation are re-screened every six months. This is especially critical for infants and toddlers in foster care who, as a result of having multiple caregivers, may not have a caregiver who is able to recognize when a child is delayed.

(2) *Biological and Adoptive Parents Should Participate in Decisionmaking.*

Identifying and referring at-risk children is only the first step. Someone must consent to the child’s initial evaluation, participate in the development of the IFSP, monitor whether services are being delivered, and use the hearing procedures when necessary. Children are usually placed in care only temporarily (or have only entered care to gain access to other services) and will return home to their biological families. National child welfare statistics indicate that nearly 20% of children in foster care stay in care for only one month, and another 16% remain in care for 5 months or less.¹³ Over half of all children who leave foster care will be returned home to their parents. Therefore, it is crucial that the biological or adoptive parent serve as the education decisionmaker whenever the parent is willing and able to perform that function.¹⁴

We propose that the regulations clarify that:

- School entities must treat the biological or adoptive parent as the parent – that is, provide notice and accommodate the person’s schedule.
- The determination of whether the biological or adoptive parent is “attempting to act” as the parent must be based not on a single missed meeting, but on a comprehensive assessment of whether the parent is attempting to perform her role as participant and decisionmaker in the early intervention process.

(3) *Qualified Decisionmakers Must Be Identified and Appointed Promptly.*

In cases where an infant or toddler’s need for an alternate decisionmaker is clear, it is vital that an appropriate surrogate parent be appointed as soon as possible. We propose that the regulations:

- Make clear that the surrogate parent cannot be a person involved in the education or care of the child.
- Include a 30-day timeline for the appointment of a surrogate parent.
- Make sure that the child’s caregiver and the child welfare agency receive notice of key decisions.

¹³ AFCARS Report, 4 n.9 *supra*.

¹⁴ Advocates for Children’s Project Achieve: A Model Project Providing Education Advocacy for Children in the Child Welfare System (Advocates for Children of New York, Inc., March 2005), *available at* <http://www.advocatesforchildren.org/pubs/ProjectAchievefinal.doc>.

(4) *Children in Out-of-Home Care Should Have Access to Early Intervention Services Designed to Address Abuse, Neglect (Including Abandonment), and Family Violence.*

Recent studies indicate that trauma experienced in childhood is the single most important factor in predicting negative outcomes later in life. Children who are exposed to family violence, alcohol or drug abuse, or are victims of abuse or neglect (including abandonment) are more likely to drop out of school, smoke, and become alcoholics.¹⁵ These behaviors in turn result in increased risk of negative health outcomes (such as diabetes, heart disease, and cancer), disability, and early death.¹⁶ These stark statistics highlight the need for teaching methodologies and training specifically designed to address the unique needs of these children by creating safe, stable environments in which they can learn. We propose that the regulations:

- Clarify that the “scientifically-based research” required by the IDEA can include approaches that work effectively for children in the child welfare system who experience or are exposed to abuse, neglect (including abandonment), or family violence.

¹⁵ Vincent J. Felitti, *The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study* (Department of Preventative Medicine, Kaiser Permanente Medical Care Program, 2004), available at <http://www.acestudy.org/docs/OriginsofAddiction.pdf>.

¹⁶ *Ibid.*

**Specific Comments and Proposed Revisions to the Part C Regulations
Relating to Children in Out-of-Home Care**

I. THE REGULATIONS SHOULD CONSISTENTLY REFERENCE ALL CHILDREN IN OUT-OF-HOME CARE (WARDS OF THE STATE AND CHILDREN IN FOSTER CARE) – §§ 303.1(d), 303.27(a), 303.112, 303.227, and 303.520(a)

Recommendations:

- Part C regulations referring to any subset of children in out-of-home care should specifically refer to both “children in foster care” and “wards of the State.”

Proposed Regulatory Language:¹⁷

§ 303.1(d)

The purpose of this part is to provide financial assistance to States to...**(d) Enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of all children, including historically underrepresented populations, particularly minority, low-income, inner-city, and rural children, and infants and toddlers in foster care *and wards of the State.***

§ 303.27(a)

- (a) Parent means –
- (1) A biological or adoptive parent of a child;
 - (2) A foster parent, unless State law, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;
 - (3) A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State ***or in foster care***);
 - (4) An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or
 - (5) A surrogate parent who has been appointed in accordance with § 303.422 or section 639(a)(5) of the Act.

§ 303.101(a)

- (a) Assurances regarding early intervention services and a Statewide system. The State must provide assurances to the Secretary that –

¹⁷ Throughout this document, proposed new text appears in ***bold italics***, while text which we recommend omitting appears in ~~strike through~~. For the full text of our proposed changes, *see* the Appendix to this document.

(1) The State has adopted a policy that appropriate early intervention services are available to all infants and toddlers with disabilities in the State and their families, including –

- (i) Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in the State;
- (ii) Infants and toddlers with disabilities who are homeless children and their families; and
- (iii) Infants and toddlers with disabilities who are wards of the State *or in foster care*.

§303.112

Each system must include a State policy that is in effect and that ensures that appropriate early intervention services are based on scientifically based research, to the extent practicable. These services shall be made and are available to all infants and toddlers with disabilities and their families, including –

- (a) Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in the State; and
- (b) Infants and toddlers with disabilities who are homeless children and their families;
and
- (c) *Infants and toddlers who are wards of the State or in foster care.*

§303.227

The State must ensure that policies and practices have been adopted to ensure –

- (a) That traditionally underserved groups, including minority, low-income, homeless, and rural families and children with disabilities who are wards of the State *or in foster care*, are meaningfully involved in the planning and implementation of all the requirements of this part; and
- (b) That these families have access to culturally competent services within their local geographical areas.

§303.520(a)

(a) Public insurance and benefits.

(1) The State may use the public insurance or benefits program of a parent or infant or toddler with a disability under this part (consistent with the program requirements of the public insurance or benefits program), if –

- (i) The parent or the infant or toddler with a disability is already enrolled or participating in a public insurance or benefits program, provided that the parent provides consent as defined in § 303.7 to disclose personally identifiable information if required under § 303.414;
 - (ii) The parent has not provided consent under §§ 303.7, 303.414, or 303.420(a)(3), but the infant or toddler with a disability is in foster care *or a ward of the State* and eligible to participate in the public insurance or benefits program;
- or

(iii) The parent is not enrolled in a public insurance or benefits program but agrees to enroll and provides consent to enroll in a public insurance or benefits program in accordance with §§ 303.7, 303.414, and 303.420(a)(3).

Explanation of Recommendations:

Section 631(a)(5) of the IDEA states that Congress “finds there is an urgent and substantial need...to enhance the capacity of the State and local agencies and service providers to identify, evaluate, and meet the needs of all children, particularly minority, low-income, inner city, and rural children, **and infants and toddlers in foster care**” (emphasis added).¹⁸ Based on this clear legislative intent, it is important to ensure that all children in foster care placements, as well as children placed by the child welfare system in institutional placements, are included in Part C’s protections. The proposed regulatory definition of “ward of the State” (§ 303.36) excludes children in foster care who have foster parents who meet the definition of parent under § 303.27. Only in § 303.301(b)(ii) do the proposed regulations include both children in foster care and wards of the State. This approach should be used uniformly throughout this Chapter.

II. REFERRALS UNDER THE CHILD FIND SYSTEM OR DISCRETIONARY REFERRALS THROUGH INCLUSION AS AN AT-RISK INFANT OR TODDLER – §§ 303.302(a)-(b) and 303.5

Recommendations:

- We propose that the provision setting out the circumstances under which a referral is mandatory under the child find system be amended to include certain conditions which are well known to cause significant developmental delays: exposure to dangerous levels of lead paint, exposure to alcohol abuse, fetal alcohol exposure, abandonment, and having a substantiated case of trauma due to exposure to family violence.
- Alternatively, if the child find provision is not amended, we propose that the definition of “at-risk” children be expanded to specifically include references to lead paint exposure, exposure to alcohol abuse, fetal alcohol exposure, abandonment, and exposure to family violence in the list of “biological and environmental factors” contributing to an increased risk of developmental delays. This change will facilitate the referral of all needy children for screening to determine whether further evaluation is required.

Proposed Regulatory Language:

§ 303.302(a)-(b)

(a) General.

- (1) The child find system described in § 303.301 must include procedures for use by primary referral sources for referring a child to the Part C system for
- (i) Evaluation and assessment, in accordance with § 303.320; and
 - (ii) As appropriate, the provision of early intervention services, in accordance with §§ 303.342 through 303.345.

¹⁸ 20 U.S.C. § 1431(a)(5).

(b) The procedures required in paragraph (a) of this section must provide for requiring the referral of child under the age of three who –

(1) Is involved in a substantiated case of abuse or neglect (*including abandonment*);

or

(2) Is identified as affected by illegal substance *or alcohol* abuse or withdrawal symptoms resulting from prenatal drug *or alcohol* exposure;

(3) *Is identified as having been exposed to dangerous levels of lead paint*

(4) *Is identified as having a substantiated case of trauma due to exposure to family violence (as defined in section 320 of the Family Violence Prevention and Services Act.)*

OR

§ 303.5

At the State's discretion, at-risk infant or toddler may include an infant or toddler who is at risk of experiencing developmental delays because of biological and environmental factors that can be identified such as low biological weight, respiratory distress as a newborn, lack of oxygen, brain hemorrhage, infection, nutritional deprivation, *exposure to dangerous levels of lead paint*, and a history of abuse or neglect (*including abandonment*) *of the child or other children in the home, exposure to family violence*, being directly affected by illegal substance *or alcohol* abuse or withdrawal symptoms resulting from prenatal drug *or alcohol* exposure.

Explanation of Recommendations:

Subsection § 303.302(a)-(b) isolates certain factors as sufficiently linked to developmental delays to merit a mandatory referral. For the reasons discussed herein, exposure to dangerous levels of lead paint, exposure to alcohol abuse, prenatal alcohol exposure, and abuse or neglect (including abandonment) place children at significant risk for developmental delays and are more common for children who are or eventually will be in the custody of the child welfare system. We therefore recommend adding these factors to the existing list of conditions warranting mandatory referral.

Alternatively, our fallback recommendation is to add these conditions to the list of optional indicators set forth in the definition of “at-risk infant or toddler” under section § 303.5. This section governs discretionary referrals by the State and identifies specific factors (such as low birth weight and nutritional deprivation) which create an increased likelihood of developmental delays.

Prenatal Alcohol Exposure

The discussion of comments to proposed Part B regulations addressed commenters’ requests to create a separate disability category for children suffering from fetal alcohol syndrome (FAS), arguing the regulations as written already covered children suffering from FAS and declining to create a separate category.¹⁹ Our recommendation here, to include references to

¹⁹ 71 Fed. Reg. 46,540, 46,549.

exposure to alcohol abuse and prenatal alcohol exposure, is not a request to create a separate disability category for children with FAS. Instead, our recommendation reflects the reality that while “drug exposure” is an obvious red flag and may automatically prompt a referral to early intervention services, alcohol exposure is often not perceived as such a danger. Many scientific studies (including the ACE study, discussed below) emphasize the strong correlation between exposure to alcohol and increased developmental delays and health problems. It is important to list alcohol exposure explicitly to ensure that all children placed at risk physically, physiologically or emotionally will be referred for screening.

Children whose mothers drink during pregnancy are at risk for Fetal Alcohol Syndrome (FAS) and Alcohol-Related Neurodevelopmental Disorder (ARND), both of which are characterized by brain damage. This brain damage often manifests as intellectual difficulties or behavioral problems.²⁰ ARND is of particular concern with respect to these regulations because the brain damage occurs absent the characteristic facial abnormalities which accompany FAS, and thus is more difficult to detect and diagnose early. For every child born with FAS, it is estimated three additional children are born who do not have the physical characteristics of FAS but still experience neurobehavioral deficits resulting from prenatal alcohol exposure.²¹ Prenatal alcohol exposure increases the risk of deficits in growth, behavior, and neurocognition problem in math, language, and memory, visual-spatial abilities, attention, and speed of information processing,²² as well as childhood depression.²³ The majority of infants in foster care are prenatally exposed to maternal substance abuse.²⁴

Exposure to Dangerous Levels of Lead Paint

It is equally important to add exposure to dangerous levels of lead paint to the list of indicators requiring referral under the child find system. A child with an elevated blood lead level (EBLL) of 10 micrograms per deciliter (ug/dL) is considered lead poisoned.²⁵ Children in out-of-home care often have a history of child abuse or neglect, developmental delays, behavioral problems, failure to thrive, and living in poverty.²⁶ Each of these factors corresponds with an increased prevalence of lead poisoning. A 2001 study found that before placement, children in foster care are nearly twice as likely to have elevated blood lead levels (EBLLs) as children in the general population. The study found 50% of children in foster care had EBLLs greater than or equal to 20 ug/dL before placement, while 90% of the same group had EBLLs greater than or equal to 10 ug/dL.²⁷ Given these statistics, it is important to screen as many

²⁰ Alcohol Alert, (National Institute on Alcohol Abuse and Alcoholism of the National Institute of Health, 2000), available at <http://pubs.niaaa.nih.gov/publications/aa50.htm>.

²¹ Surgeon General Advisory on Alcohol Use in Pregnancy (U. S. Department of Health and Human Services, 2005), available at <http://www.surgeongeneral.gov/pressreleases/sg02222005.html>.

²² *Ibid.*

²³ Mary J. O'Connor & Blair Paley, *The Relationship of Prenatal Alcohol Exposure and the Postnatal Environment to Child Depressive Symptoms*, *Journal of Pediatric Psychology* (2006), available at http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=PubMed&list_uids=15802607.

²⁴ *Building Bridges for Babies in Foster Care*, 3 n.4 *supra* at 30.

²⁵ Preventing Lead Poisoning in Young Children (Centers for Disease Control and Prevention, 1991), available at <http://wonder.cdc.gov/wonder/prevguid/p0000029/p0000029.asp>.

²⁶ Esther K. Chung et al., *A Comparison of Elevated Blood Lead Levels Among Children Living in Foster Care, Their Siblings, and the General Population*, *Pediatrics*, (2001).

²⁷ *Ibid.*

children as possible who are suspected of having been exposed to dangerous levels of lead paint. Including exposure to lead paint explicitly emphasizes its importance as a risk factor for developmental delays.

Exposure to Violence, Alcohol Abuse, or Drug Abuse in the Home

The Adverse Childhood Experiences (ACE) Study asks participants to self-report²⁸ childhood experiences and then compares those reports to adult health status about 50 years later by measuring adult physical and mental health against a checklist of eight childhood trauma indicators. The presence of an alcoholic or drug abuser in the household, recurrent and severe emotional abuse, and exposure to violence against the mother are some of the ACE indicators. A participant in the study is given one point for each indicator out of the eight present in childhood, so that each person has an ACE score between one and eight. The presence of even one ACE factor in childhood markedly increases the likelihood the child will become an adult smoker, alcoholic, or intravenous drug user, with the increases compounded as the ACE score increases. The study clearly shows that adverse childhood experiences are the “main determinant of the health and social well-being of the nation.”²⁹

We recommend requiring referral for screening of all children identified as having a substantiated case of trauma due to exposure to family violence. This proposal tracks the language tracks of § 303.211(b)(7), which recognizes the impact trauma due to exposure to family violence may have on a child. Researchers have now linked exposure to violence in the early years to permanent damage to the development of the brain.³⁰ Even when family violence does not result directly in injury and illness, studies suggests that children exposed to family violence cope with their situation and feelings in ways that are harmful to their health. Children living with family violence have an increased risk of adopting self-destructive and health-harming behaviors.³¹ A study of youth living on the streets in Toronto found that 70% had been exposed to family violence.³² In addition, people who experience family violence are at greater risk of mental health disorders. In view of the established link between exposure to family violence and developmental and educational delays, we recommend adding this condition as one warranting mandatory referral.

Abuse or Neglect (Including Abandonment)

The current proposed regulations §§ 303.302(a)-(b) and 303.5 use the language “substantiated case of” and “history of”, respectively, when referring to children affected by abuse and neglect. We propose expanding the language in § 303.5 to cast a slightly wider net by referring children who live with siblings or other children who have a history of abuse or neglect.

²⁸ The ACE study may in fact understate the long-term effects of trauma in childhood because underreporting is likely when asking participants to discuss their own negative family experiences.

²⁹ Vincent J. Felitti, 6 n.15 *supra*.

³⁰ Martin Teicher, *The Neurobiology of Child Abuse*, 70 (Scientific American, March 2002).

³¹ Jill Astbury et al., *The Impact of Domestic Violence on Individuals*, 427-431 (Medical Journal of Australia, 2000), available at http://www.mja.com.au/public/issues/173_08_161000/astbury/astbury.html, last visited October 2002..

³² R. G. Smart et al., *Drifting and Doing: Changes in Drug Use Among Toronto Street Youth* (Toronto Addiction Research Foundation, 1992).

Proposed § 303.211(b)(7) provides a model for this approach by requiring referral of children who experience trauma due to exposure to family violence. This provision recognizes the potential damaging effects and contribution to developmental delays of the presence of any type of abuse and neglect in a child's home even where the child is not a documented victim. Including a reference to the experiences of other children in the home in the regulatory language ensures the referral of all children who may be hurt by abuse and neglect, whether directly or indirectly.

We also propose clarifying that children who have entered the child welfare system because their families have abandoned them are included in the terms "abuse or neglect". While it is difficult to obtain up-to-date or reliable statistical information regarding the long-term effects of abandonment,³³ there is some information available about common familial circumstances precipitating abandonment. Mothers of abandoned infants are often struggling with poverty, lack of housing, abusive relationships, HIV infection, mental illness, and drug addiction.³⁴ Children who are abandoned are more likely to experience a host of physical, social, and cognitive developmental problems.³⁵

It is well known that early intervention services are critical for those who are victims of or have been exposed to abuse and neglect (including abandonment). Moreover, prompt referrals for early intervention services may be critical to breaking the cycle of abuse experienced by disabled children. According to research performed by Boys Town National Research Hospital, children with disabilities are at greater risk of becoming victims of abuse and neglect than children without disabilities. This study disclosed that children with disabilities are 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused than children without disabilities.³⁶ Another study found the overall incidence of child maltreatment to be 39% in 150 children with multiple disabilities.³⁷ In a 2000 study of more than 4500 maltreated children, researchers observed that children with disabilities were 3.79 times more likely to be neglected, 3.79 times to be physically abused, and 3.14 times more likely to be sexually abused when compared with children without disabilities.³⁸

The dramatically increased health risks associated with exposure to dangerous levels of lead paint, exposure to alcohol abuse in the home, exposure to family violence, and prenatal alcohol exposure properly belong in the same category as exposure to drug abuse, prenatal drug exposure, and substantiated cases of abuse and neglect in the context of mandatory referrals under the child find system. Early screening and treatment is essential to minimizing the long-term damage to these children, and, without exception, children in out-of-home care are more likely to be subject to these conditions. Including these factors in the mandatory referral system

³³ "The federal government and most states do not keep statistics specific to abandoned newborns. There is presently no way to determine what portion of infant deaths are due to abandonment." Save Abandoned Babies Foundation FAQ, <http://www.saveabandonedbabies.org/qa.html>.

³⁴ Boarder Babies, Abandoned Infants, and Discarded Infants, 2 (National Abandoned Infants Assistance Resource Center, December 2005), available at http://aia.berkeley.edu/media/pdf/abandoned_infant_fact_sheet_2005.pdf.

³⁵ *Ibid* at 3.

³⁶ Roberta A. Hibbard et al., *Maltreatment of Children with Disabilities*, 1018, 1019, *Pediatrics* (2007), available at <http://www.pediatrics.org/cgi/content/full/119/5/1018>.

³⁷ Roberta A. Hibbard, 13 n.36 *supra*.

³⁸ *Ibid*.

under § 303.302(a)-(b) will ensure early, appropriate treatment for a population frequently lacking effective and consistent advocates. If, however, the Department rejects our recommendation, we alternatively propose that these conditions be referenced in the definition of “at-risk” infant or toddler set forth in § 303.5 in order to facilitate the discretionary referral of children who are at a high risk of experiencing developmental delays.

III. REFERRAL OF CHILDREN WHO HAVE EXPERIENCED TRAUMA – § 303.211(b)(7)

Recommendations

- We recommend revising the regulation that currently requires that only children age 3 and older who experience trauma be referred to the early intervention system to include all Part C eligible children who met this criterion. This recommendation is consistent with the description of this regulation in the Department’s comments stating that all children eligible for Part C, including but not limited to those over age 3 in states that opt to permit children to remain in Part C, must be referred for screening if they experience trauma and violence.
- We suggest clarifying the parental consent language of the provision regarding the referral of children who experience trauma as a result of exposure to family violence to ensure the safety and confidentiality of the parent or caregiver who was the victim of abuse while ensuring that children are appropriately referred for screening.

Proposed Regulatory Language:

303.211(b)(7):

State option to make services available to children ~~ages three and older~~ *who experience trauma*

(b)

(7) For all children eligible for part C services, including children ages three and older in States that adopt the option to make services under this part available to children ages three and older, there will be a referral to the Part C system, dependent upon parental consent *of the parent who has been the subject of abuse*, of a child under the age of three who directly experiences a substantiated case of trauma due to exposure to family violence. *Where it is suspected that a child’s parent or caregiver may also be at risk of violence, any referral and/or consent shall be accomplished in a manner to protect the safety and confidentiality of the parent or caregiver who may be at risk.*

Explanation of Recommendations:

We recommend modifying the title and language of § 303.211(b)(7) to reflect the intent conveyed by the Department’s accompanying explanation to the proposed regulations. This provision requires a referral for evaluation of children who experience a substantiated case of trauma due to exposure to family violence. However, the current language and location of this provision restrict the mandatory referral of children who experience trauma to those older than

three who live in States which have opted to offer early intervention services beyond age three. This is a small subset of the overall population eligible for early intervention services and the explanation published in the Federal Register mentions no such restriction. Rather, it states: “Proposed Sec. 303.211(b)(7) would require a referral for evaluation for early intervention services of a child **under the age of three...**” (emphasis added). Because there is no principled reason for restricting this referral to children over three living in States where they remain eligible for early intervention services, and in light of the Department’s comments making clear that the Department understands this referral to be required for *all* children eligible for early intervention services, we recommend modifying the language to reflect the Department’s position.

We also propose a modification to the parental consent provision of § 303.211(b)(7). Recognizing the particular dangers associated with family violence, we propose clarifying that the consent of the parent who is the subject of the abuse be the only parental consent that is required. Requiring the consent of a parent who is an abuser would operate to prevent some of the neediest infants and toddlers from being referred to the Part C system, but removing the consent provision entirely risks placing a parent who is being abused in danger. We also suggest the addition of language ensuring that whenever family violence against a household member other than the child is suspected, all possible steps will be taken by Part C service providers to protect the abused household member’s safety and confidentiality.

IV. TIMELINE UNDER THE CHILD FIND SYSTEM – § 303.302

Recommendation:

- Specify a ten-day limit for referring a child under the child find system.

Proposed Regulatory Language:

§303.302

- (a) General. (The child find system described in Sec. 303.301 must include procedures for use by primary referral sources for referring a child to the Part C system for – ...
- (b) Referral of specific at-risk children. The procedures required in paragraph (a) of this section must provide for requiring the referral of a child under the age of three who – ...
- (c) Primary referral sources. As used in this subpart, primary referral sources include – ...
- (d) Referral of a child under the child find system shall occur within ten working days.*

Explanation of Recommendation:

When a child is at heightened risk for developmental delays, speedy referral is essential.³⁹ As previously discussed, all children in out-of-home care are more likely to experience developmental delays and those children exposed to specific known risk factors are even more vulnerable. For these reasons, we recommend that a ten-day referral time limit be added to § 303.302. This recommendation is more flexible than the former regulatory two-day timeline and preferable to the absence of any guideline as currently proposed by the Department. We do not dispute the Department's position that the Department has "limited ability to enforce such a timeline given that primary referral sources include private physicians and other individuals and entities that are not EIS providers."⁴⁰ However, including a ten-day timeline will offer guidance to primary referral sources on what is considered reasonable, and the dissemination of the timeline via trainings will likely have some beneficial effect. It is extremely likely children experiencing the factors listed in § 303.302(b) (with our recommended additions) will require early intervention services. The earlier these services can begin, the more likely it is that the child will avoid the negative outcomes associated with developmental delays. Even an imperfectly enforceable timeline will facilitate more rapid referral of children in need.

V. DEFINITION OF PARENT – § 303.27

Recommendations:

- Define "attempting to act" by explicitly requiring it to be based on a comprehensive assessment of the biological or adoptive parent's involvement in the early intervention process.
- Include a provision expressly requiring lead agencies to treat biological or adoptive parents of children in foster care or wards of the State as they would any other parent.
- Delete the authority to make "health" decisions from the list of circumstances disqualifying the biological or adoptive parent from being the early intervention decisionmaker.
- Add "temporarily or permanently" in the section on judicial appointments of IDEA parents to reflect a judge's option to appoint a temporary decision maker for a foster child.
- Replace "other services" with "child welfare services" in the provision limiting who a judicial order may identify as a child's IDEA parent.

³⁹ For example, one of the most common causes of developmental delay is hearing loss. Because of the way babies acquire language, it is crucial infants with hearing impairments be diagnosed and begin treatment before six months of age. This greatly increased the chance the child will acquire language – whether spoken or signed. *See* Hearing Problems in Children, Medline Plus (A service of the U. S. National Library of Medicine and National Institutes of Health), available at <http://www.nlm.nih.gov/medlineplus/hearingproblemsinchildren.html>.

⁴⁰ 72 Fed. Reg. 26,455, 26,471.

Proposed Regulatory Language:

§ 303.27

- (a) Parent means –
- (1) A biological or adoptive parent of a child;
 - (2) A foster parent, unless State law, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;
 - (3) A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, ~~health~~ or developmental decisions for the child (but not the State if the child is a ward of the State);
 - (4) An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or
 - (5) A surrogate parent who has been appointed in accordance with § 303.422 or section 639(a)(5) of the Act.
- (b)
- (1) Except as provided in paragraph (b)(2) of this section, the biological or adoptive parent, when attempting to act as the parent under this part and when more than one party is qualified under paragraph (a) of this section to act as a parent, must be presumed to be the parent for purposes of this section unless the biological or adoptive parent does not have legal authority to make ~~health, educational or early intervention services~~, **educational, or developmental** decisions for the child. ***The phrase “attempting to act” as used in this Section shall be based on a comprehensive assessment of a person’s efforts to act as the parent with respect to developmental, educational or early intervention decisions. Accordingly, a failure to attend a particular meeting or appointment shall be insufficient to preclude a person from acting as a parent under this Section.***
 - (2) If a judicial decree or order identifies a specific person or persons under paragraphs (a)(1) through (a)(4) of this section ***temporarily or permanently*** to act as the “parent” of a child or to make ~~health, educational, or early intervention service~~, **educational, or developmental** decisions on behalf of a child, then the person or persons must be determined to be the “parent” for purposes of Part C of the Act, except that ***an employee of*** the lead agency or any other public agency or EIS provider that provides early intervention to the child or any family member of the child, or ~~other~~ ***child welfare*** services to the child may not act as the parent.
 - (3) ***The lead agency shall make every effort to fully include and make all accommodations necessary to ensure that the requirements of the Act are followed with respect to biological and adoptive parents of children in foster care or wards of the State, including providing notice and other procedural protections.***

Explanation of Recommendations:

The Department’s proposed revisions to § 303.27(b) state that the phrase “attempting to act as the parent” is intended to “assist EIS providers and public agencies in identifying the appropriate person to serve as the parent under Part C of the Act, especially in those difficult situations in which more than one caregiver is available to provide consent for evaluation or the

provision of early intervention services and to make other decisions under Part C of the Act.”⁴¹ Recognizing that the majority of infants and toddlers in out-of-home care will eventually return to live with their biological or adoptive parents, and consequently that the continued involvement of biological or adoptive parents in the decisionmaking process is an extremely important goal, we recommend incorporating a definition for “attempting to act” into the Part C regulations, and that the definition be designed to support the active involvement of biological or adoptive parents whenever possible.

In our comments to the proposed regulations to Part B, we were among commenters requesting that “attempting to act” be removed from the regulatory language as overly vague. The discussion of this suggestion in the final published regulations rejected the proposed deletion, and continued: “We do not believe it is necessary or possible to include in these regulations the numerous situations in which an individual may attempt to act as the parent.”⁴² While we agree that a definition listing each possible scenario is both unnecessary and impossible, we recommend adding a limited definition which provides some guidance for interpreting the phrase within the regulations.

- Our proposed definition requires that the question of whether a biological or adoptive parent is “attempting to act” as the parent be resolved via a “comprehensive assessment” of the parent’s efforts. Anecdotal evidence suggests that some biological or adoptive parents are deemed to have failed the “attempting to act” test on the basis of single action or inaction. In view of the importance of continuing to foster biological or adoptive parent involvement while a child is in out-of-home care, whether a parent is considered to be “attempting to act” should never hinge on a failure or inability to attend a particular meeting or meetings if the parent is actively trying to fulfill her parental responsibilities in the early intervention process.
- Recognizing that biological or adoptive parents must be given the opportunity to act as parents before they can satisfy the requirements of “attempting to act” under Part C, the definition of “attempting to act” should also include a requirement that lead agencies treat biological and adoptive parents of children in out-of-home care as they would any other parents with respect to notice and other procedural protections. This provides biological and adoptive parents the maximum opportunity to demonstrate their desire and ability to remain involved in early intervention decisions for their child.

We also propose eliminating “health decisions” from the list of powers that disqualify a biological or adoptive parent from acting as a child’s parent under the IDEA. The regulations’ current proposed language defines a parent as a guardian authorized to make “health,” educational, early intervention, or developmental decisions for the child. The parallel provisions in Part B list only educational decisionmaking power.⁴³

We recommend striking health from the list because it is an extremely overbroad category. Judges may make the decision that there should be a decisionmaker appointed to make health determinations for a child without in any way intending to limit the biological parent’s

⁴¹ 72 Fed. Reg. 26,456, 26,461.

⁴² 71 Fed. Reg. 46,540, 46,567.

⁴³ 34 C.F.R. § 300.30(a)(3), (b)(1)-(2).

role in early intervention decisionmaking. Only a court order that specifically appoints another decisionmaker for early intervention, educational, or developmental decisions should divest the biological parent of her ability to represent the child in the early intervention system.

In order to make clear that alternate decisionmakers under the IDEA may be either temporarily or permanently appointed by judges, we propose adding explicit language to that effect.

We also recommend replacing “other services” with “child welfare services” in the provision limiting who may be appointed as a child’s IDEA parent. “Child welfare services” more properly tracks the scope of a limitation designed to prevent the appointment of a parent who would have a professional conflict of interest, while the more general “other services” would operate to exclude potentially appropriate IDEA parents such as the child’s attorney.

VI. EARLY INTERVENTION SERVICES AND PERSONNEL DEVELOPMENT SENSITIVE TO THE NEEDS OF CHILDREN IN THE CHILD WELFARE SYSTEM – §§ 303.112 and 303.118

Recommendations:

- Add a reference to “approaches specific to the needs of children who have experienced or have been exposed to abuse, neglect (including abandonment), or family violence” in the provision requiring appropriate early intervention services to be based on scientifically-based research.
- Include a parallel reference in the provision detailing personnel development system requirements.

Proposed Regulatory Language:

§ 303.112

Each system must include a State policy that is in effect and that ensures that appropriate early intervention services are based on scientifically based research, to the extent practicable, *including approaches specific to the needs of children who have experienced or have been exposed to abuse, neglect (including abandonment), or family violence. These services shall be made* ~~and are~~ available to all infants and toddlers with disabilities and their families, including –

- (a) Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in the State; ~~and~~
- (b) Infants and toddlers with disabilities who are homeless children and their families

§ 303.118

Each system must include a comprehensive system of personnel development, including the training of paraprofessionals and the training of primary referral sources with respect to the basic components of early intervention services available in the State, that—

- (a) Must include—
 - (1) Implementing innovative strategies and activities for the recruitment and retention of EIS providers;
 - (2) Promoting the preparation of EIS providers who are fully and appropriately qualified to provide early intervention services under this part; and
 - (3) Training personnel to coordinate transition services for infants and toddlers with disabilities who are transitioning from an early intervention services program under Part C of the Act to a preschool program under section 619 of the Act, Head Start, Early Head Start, an elementary school program under Part B of the Act or another appropriate program; and
- (b) May include—
 - (1) Training personnel to work in rural and inner-city areas;
 - (2) Training personnel in the emotional and social development of young children, ***including approaches specific to the needs of children who have experienced or have been exposed to abuse, neglect (including abandonment), or family violence;*** and
 - (3) Training personnel to support families in participating fully in the development and implementation of the child's IFSP.

Explanation of Recommendations:

Children in out-of-home care are more likely than other children to have suffered trauma due to abuse, neglect, or exposure to family violence. As a result, they are more likely to be classified as having emotional or behavioral problems. Sadly, the post-traumatic stress disorder rates of foster care children exceed those of American Gulf War veterans.⁴⁴ Specific methodologies have been developed to deal with the unique circumstances of children who have suffered trauma, with an end goal of increasing teaching and learning time while decreasing time spent on discipline.⁴⁵ The U. S. Department of Health and Human Services Substance Abuse and Mental Health Services website provides an overview of these programs and services, calling them the “new generation of transformed mental health and allied human services organizations and programs who serve people with histories of violence and trauma.”⁴⁶ These approaches are compatible with Congress’s expressed intent to incorporate scientifically-based research into early intervention services and to train personnel in the emotional and social development of young children to whom services are provided.⁴⁷

A growing body of research suggests that trauma experienced early in life is the most significant factor in determining a person’s risk for social, emotional and cognitive impairment, adoption of health-risk behaviors such as alcoholism, smoking, or intravenous drug use, disease, disability, and early death.⁴⁸ The Adverse Childhood Effects (ACE) study, which examined the health and social effects of trauma in childhood (such as physical abuse, sexual abuse, or

⁴⁴ Scott Jofus, 3 n.5 *supra* at 7.

⁴⁵ Susan Cole et al., *Helping Traumatized Children Learn: A Report and Policy Agenda* (Massachusetts Advocates for Children, 2005), available at http://www.massadvocates.org/trauma_and_learning_policy_initiative.

⁴⁶ U.S. Department of Health and Human Services – Substance Abuse and Mental Health Services Administration. <http://mentalhealth.samhsa.gov/nctic/trauma.asp>.

⁴⁷ 20 U.S.C. § 1435(a)(2), (8).

⁴⁸ Vincent J. Felitti, 6 n.15 *supra*.

exposure to abuse of the mother), demonstrates that the impacts of trauma are cumulative, correlating strongly with increased risk of heart disease, cancer, liver disease, and HIV-AIDS.⁴⁹

Training in and implementation of methodologies responsive to these experiences is critical. Because exposure to abuse, neglect or abandonment often manifests as inability to focus or “acting out” in children, trauma may be incorrectly diagnosed as depression, ADHD, ODD, conduct disorder, generalized anxiety disorder, separation anxiety disorder, and reactive attachment disorder.⁵⁰ Incorrect diagnosis leads to inappropriate treatment and medication.

A 2005 report prepared by Massachusetts Advocates for Children in collaboration with The Hale and Dorr Legal Services Center of Harvard Law School and The Task Force on Children Affected by Domestic Violence found that because education and services providers are often unaware of a child’s exposure to (or of the extent of exposure to) trauma, implementation of trauma-informed approaches in all settings will benefit all children – “those whose trauma history is known, those whose trauma will never be clearly identifies, and those who may be impacted by their traumatized classmates.”⁵¹ Studies estimate that between 3.3 million and 10 million children in the U.S. witness violence in their own homes each year.⁵² For these children, specific resources must be readily available to mitigate the long-term damaging effects of trauma.

Absent adequate resources to assist in coping, the “alarm state” resulting from trauma “may persist even when the immediate danger has passed, and this can lead to PTSD. Excessive and repeated stress causes the release of chemicals that disrupt brain architecture by impairing cell growth and interfering with the formation of healthy neural circuits. When trauma occurs repeatedly, permanent changes in the brain can occur, compromising core mental, emotional, and social functioning – and resulting in a brain that is focused on surviving trauma.”⁵³

Scientists in the mental health field recognize the far-reaching effects of childhood traumatic experiences. Coalitions of scientists, doctors, legal advocates, and social organizations across the country are recommending the integration of trauma-informed approaches into educational and developmental services for children.⁵⁴ Based on the overwhelming evidence that early and appropriate response to trauma is critical in mitigating serious long-term effects and their corresponding societal costs, and because children in the child welfare system are very likely to need approaches that reflect their special and traumatic life experiences, we recommend a specific reference to approaches that are specific to and appropriate for children who have experienced or have been exposed to abuse, neglect, or family violence. This provision will encourage awareness and adoption of these methodologies by early intervention providers who otherwise may not be aware of the best way to address these children’s special needs.

⁴⁹ Trauma – the “Common Denominator” (Witness Justice and CMHS’s National Center for Trauma-Informed Care), *available at* <http://mentalhealth/samhsa.gov/nctic/trauma.asp> (click on “The Science of Trauma” link in the upper right hand box.

⁵⁰ *Ibid.*

⁵¹ Susan Cole, 21 n.45 *supra*.

⁵² *Ibid.*

⁵³ Trauma – the “Common Denominator,” 21 n.49 *supra*

⁵⁴ *See, e.g.,* A Closer Look: Trauma Informed Treatment in Behavioral Health Settings (Ohio Legal Rights Service, 2007), *available at* <http://olrs.ohio.gov/other/trauma.pdf>.

VII. PUBLIC PARTICIPATION POLICIES AND PROCEDURES AND PROCEDURES FOR ASSESSMENT OF THE FAMILY – §§ 303.320(c) and 303.208

Recommendation:

- Supplement language referring to families or parents of infants and toddlers with disabilities with specific references to foster parents and caregivers.

Proposed Regulatory Language:

§ 303.208

(a) Each application must include a description of the State's policies and procedures that ensure that—

(1) Before adopting any new or revised policies and procedures needed to comply with Part C of the Act (including any amendments to those policies and procedures), the lead agency holds public hearings, gives adequate notice of the hearings, and provides an opportunity for comment by the general public, including individuals with disabilities and parents, *foster parents, and caregivers* of infants and toddlers with disabilities;

(2) Before submitting a State application under this part (including any policies, procedures, descriptions, methods, certifications and assurances required in subparts B and C of this part), the State—

(i) Complies with the public participation requirements in paragraph (a) of this section; and

(ii) Publishes each proposed application, policy or procedure to—

(A) Ensure circulation throughout the State, at least 60 days before the date on which the application, policy or procedure is submitted to the Secretary; and

(B) Provide an opportunity for public comment for at least 30 days during that 60-day period.

(b) Before implementing any policies, procedures, and methods that are subject to the public participation requirements in this section and required to be submitted to the Secretary under subparts B and C of this part, the State must have approval by the Secretary.

§ 303.320(c)

(c) Procedures for assessment of the family. Assessment of the family means identification of the family's *or caregiver's* resources, priorities, and concerns, and the supports and services necessary to enhance the family's *or caregiver's* capacity to meet the developmental needs of the family's *or caregiver's* infant or toddler with a disability, as determined not just through the use of an assessment tool, but through a voluntary personal interview with the family *or caregiver*.

Explanation of Recommendation:

Foster parents and caregivers for children in foster care have a unique perspective that should be part of the “mix” when the state hears from the public, but these individuals rarely participate in these discussions. Including them specifically will encourage the SEA to seek them out when developing policies and procedures.

Part C is explicitly a “family-friendly” system. It is clear that the “family” is key in determining whether a child will be properly identified and served. The concept of “family” is more complicated for a child living apart from her parents in the custody of the child welfare agency. There is no definition of family in the IDEA regulations, and its colloquial use connotes the biological or adoptive family. Including caregivers other than biological or adoptive parents ensures that the person actually living with the child participates in the IFSP process, and that the team considers that person’s input in assessing the child’s developmental needs. We therefore recommend the supplementation of the words “family” and “parent” in these provisions with explicit references to caregivers and foster parents.

VIII. NOTICE, CONFIDENTIALITY, and COMMUNICATION BETWEEN AGENCIES – §§ 303.303(a)(3) and § 303.401(a)

Recommendation:

- Add language requiring notification to caregivers of infants and toddlers with disabilities and agencies assigned to care for such infants and toddlers in cases where the lead agency is aware that the child is in foster care or is a ward of the State.

Proposed Regulatory Language:

§ 303.303(a)(3)

(a) General....

(1) The child find system described in § 303.301 may include procedures for the screening of children who have been referred to Part C, when appropriate, to determine whether they are suspected of having a disability under this part. If the State lead agency elects to adopt screening procedures to determine if a child is suspected of having a disability, those procedures must meet the requirements of this section.

(2) If the screening carried out under paragraph (a) of this section or other available information indicates that the child is suspected of having a disability, the child must be evaluated under § 303.320.

(3) If the lead agency believes, based on screening and other available information, that the child is not suspected of having a disability, the lead agency must ensure that notice is provided to the parent under § 303.421. ***If the lead agency is aware the child is in foster care, is a ward of the State, or is under the supervision of a child welfare agency, notice shall also be provided to caregiver of the child and to the child welfare agency.***

(4) If, under paragraph (a)(3) of this section, the lead agency determines that the child

is not suspected of having a disability, but the parent of the child requests an evaluation, the child must be evaluated under § 303.320.

§ 303.401(a)

(a) General. Each State must ensure that the parent of a child referred under this part is afforded the right to confidentiality of personally identifiable information, including the right to written notice of, and written consent to, the exchange of that information among agencies, consistent with Federal and State laws. *In accordance with § 303.303(a)(3), where, based on screening and other information, the child is not suspected of having a disability, and is not referred for a comprehensive evaluation, and the lead agency is aware that the child is in foster care, is a ward of the State, or is under the supervision of a child welfare agency, notice shall also be sent to the caregiver of the child and the child welfare agency.*

Explanation of Recommendation:

In situations where the lead agency is aware that a child is in foster care, is a ward of the State, or is under the supervision of a child welfare agency, it is clearly to the child's advantage to require that notice be given to both the child's caregiver and to the agency responsible for caring for the child. Our recommended additions to § 303.303(a) ensure that where the lead agency already has information about the child's out-of-home care situation, it will provide such notice while still protecting the confidentiality rights of children and their parents.

IX. RESCREENING REQUIREMENT – § 303.303(a)(5)

Recommendation:

- Require re-screening by a qualified professional every six months until age three of all referred children determined ineligible for further evaluation.

Proposed Regulatory Language:

§ 303.303(a)(5)

(a) General....

(1) The child find system described in § 303.301 may include procedures for the screening of children who have been referred to Part C, when appropriate, to determine whether they are suspected of having a disability under this part. If the State lead agency elects to adopt screening procedures to determine if a child is suspected of having a disability, those procedures must meet the requirements of this section.

(2) If the screening carried out under paragraph (a) of this section or other available information indicates that the child is suspected of having a disability, the child must be evaluated under § 303.320.

(3) If the lead agency believes, based on screening and other available information, that the child is not suspected of having a disability, the lead agency must ensure that notice is provided to the parent under § 303.421.

(4) If, under paragraph (a)(3) of this section, the lead agency determines that the child is not suspected of having a disability, but the parent of the child requests an evaluation, the child must be evaluated under § 303.320.

(5) The lead agency shall ensure that all infants and toddlers who are referred for screening are subject to re-screening by a qualified professional every six months until age three.

Explanation of Recommendation:

We recommend inserting a provision at the end of § 303.401(a) mandating re-screening for all infants and toddlers who have not been referred for evaluation. These screenings should be conducted by a qualified professional every six months. Children grow and change dramatically in the first three years of their lives and developmental delays are often difficult to recognize. High-risk infants, such as those placed in foster care, require multiple points of assessment over the first three years of life because of the dynamic nature of development during these years. The interplay of frequent maturational changes, the often uneven emergence of skills in different developmental domains, and infants' unique vulnerabilities to stress and deprivation warrant ongoing examination.⁵⁵ This task is especially difficult with regard to children in foster care or who are wards of the State because such children often do not have a consistent caregiver during this critical time period. Accordingly, re-evaluating a child's progress is especially critical to ensure that children in out-of-home care are promptly identified, referred for services, and provided with the early intervention services they need.

Conducting re-screenings every six months is necessary because specific disorders often emerge over time. During this early stage of life, physicians see the emergence of developmental disorders (such as autistic spectrum disorders), developmental delays, and relational disorders (such as attachment disorders), all warranting intervention to address the condition and improve functioning. Many conditions emerging in early childhood present differently at varying stages of development, meaning serial evaluations are needed to effectively assess the infant.

The U. S. Department of Health and Human Services's Administration for Children and Families has recognized the importance of re-evaluation in describing several model programs, including the Starting Young program at the Children's Hospital of Philadelphia. In the Starting Young program, "[e]valuation follow-up is carried out by a research assistant who checks with the infant's caregiver and caseworker to see if referrals and recommendations are being followed and identifies any barriers to accessing needed services. The team conducts an extensive re-evaluation of children every 6 months."⁵⁶ This program and others recognize that a single evaluation precludes access to needed services for many vulnerable infants and toddlers who will remain unidentified. Accordingly, we recommend requiring re-screening every six months for infants and toddlers who are not referred for evaluation as a result of their initial screening.

⁵⁵ Judith Silver, 2 n.3 *supra*.

⁵⁶ Reducing Medical Neglect of Infants and Toddlers (U. S. Department of Health & Human Services Administration for Children & Families), *available at* http://cbexpress.acf.hhs.gov/nonissart.cfm?issue_id=2005-11&disp_art=1059.

X. SURROGATE PARENTS – § 303.422

Recommendations:

- Add a 30-day time frame for the assignment of surrogate parents, paralleling the 30-day time frame set forth in the surrogate parent requirements of the Part B regulations.
- Expand the consultation requirement to all persons involved with the care of the child to ensure a fully informed decision when appointing surrogate parents.
- Remove the limitation on selection of a surrogate requiring that the surrogate cannot be providing “other services” to the child. Replace this language with a requirement that a surrogate cannot be providing “child welfare services” to the child.
- Make explicit that the lead agency may not remove a surrogate parent based upon a disagreement with the surrogate parent or the surrogate parent’s refusal to consent to services.

Proposed Regulatory Language:

§ 303.422

- (a) General. Each lead agency or other public agency must ensure that the rights of a child are protected when –
- (1) No parent...can be identified;
 - (2) The lead agency, or other public agency, after reasonable efforts, cannot locate a parent; or
 - (3) The child is a ward of the State under the laws of that State.
- (b) Duty of lead agency and other public agencies.
- (1) The duty of the lead agency, or other public agency under paragraph (a) of this section, includes the assignment of an individual to act as a surrogate for the parents. ***The lead agency shall make reasonable efforts to ensure the assignment of a surrogate parent not more than 30 days after a public agency determines that the child needs a surrogate parent.*** This assignment process must include a method for—
 - (i) Determining whether a child needs a surrogate parent; and
 - (ii) Assigning a surrogate parent to the child.
 - (2) In implementing the provisions under this section for children who are wards of the State or placed in foster care, the lead agency must consult with the public agency with whom care of the child has been assigned ***and with any other persons involved in the care of the child, including but not limited to the child’s caregiver, appointed guardian, social worker, or attorney, regarding who would best serve as the child’s surrogate parent.***
- (c) Criteria for selection of surrogate parents.
- (1) The lead agency or other public agency may select a surrogate parent in any way permitted under State law.
 - (2) Public agencies must ensure that a person selected as a surrogate parent—
 - (i) Is not an employee of the lead agency or any other public agency or EIS provider that provides early intervention services ~~or other services~~ to the child or any family member of the child, ***or child welfare services to the child;***

- (ii) Has no personal or professional interest that conflicts with the interest of the child he or she represents; and
 - (iii) Has knowledge and skills that ensure adequate representation of the child. *The lead agency or other public agency shall not remove a surrogate parent based upon a disagreement with the surrogate parent or the surrogate parent's refusal to consent to proposed services.*
- (d) Non-employee requirement; compensation. A person who is otherwise qualified to be a surrogate parent under paragraph (c) of this section is not an employee of the agency solely because he or she is paid by the agency to serve as a surrogate parent. (e) Surrogate parent responsibilities. The surrogate parent has the same rights as a parent for all purposes under this part.

Explanation of Recommendations:

The surrogate parent provision set forth in Part B of the regulations requires the SEA to make “reasonable efforts to ensure the assignment of a surrogate parent **not more than 30 days after** a public agency determines that the child needs a surrogate parent” (emphasis added).⁵⁷ We recommend adding a parallel requirement in Part C specifying that the lead agency must make reasonable efforts to appoint a surrogate parent within 30 days of the date a public agency determines that a child needs a surrogate parent. This proposed revision seeks to ensure the timely appointment of surrogates for the infants and toddlers who need them for the same reasons supporting the timeline in Part B.

The Department’s explanation regarding the consultation requirement in the current proposed regulations cites the “potential increase in the number of infant or toddler referrals...recognizing that lead agencies may not have current updated data on families.” The explanation goes on to say that this requirement is not intended to be “a burden” and allows for flexible phone or email consultation.⁵⁸ We recommend expanding the consultation requirement under these flexible terms to include all persons involved in the care of the child. The appointment of the most appropriate surrogate parent is critical for each child and, as the explanation to the proposed regulations suggests, it is often difficult to know who has the most updated information concerning the family. For this reason, adding the caregiver (who may or may not be the IDEA parent), guardian, social worker, and attorney to the list of potential persons to consult will facilitate more successful searches for surrogates already invested in the child’s well-being.

As noted above in the recommended modifications to the definition of parent, § 303.27, we recommend replacing “other services” with “child welfare services” in the provision limiting who may be appointed as a child’s IDEA parent. “Child welfare services” more properly tracks the scope of a limitation designed to prevent appointment of a parent who would have a professional conflict of interest, while the more general “other services” may exclude potentially appropriate IDEA parents such as the child’s attorney.

⁵⁷ 34 C.F.R. § 300.519(h).

⁵⁸ 72 Fed. Reg. 26,456, 26,476.

Finally, our first-hand experience as well as anecdotal evidence suggests that surrogate parents are sometimes removed by lead agencies because the surrogate parent has disagreed with the recommendations of the agencies or is aggressively advocating for the child (which is precisely what a surrogate parent is appointed to do). This is why the regulations expressly limit the appointment of a surrogate parent to persons who will not have a conflict of interest. Allowing an agency to remove a surrogate parent based on the person's advocacy for the child clearly runs counter to the intent of the regulations. In light of this practice, we recommend that the regulations explicitly prohibit such conduct.

XI. STATEMENT OF SUPPORT FOR PROVISIONS CONCERNING PRIMARY REFERRAL SOURCES – §§ 303.303(c)(9)-(11), 303.301(c)(1)(i), 303.301(c)(1)(ii)(G), and 303.301(c)(1)(ii)(I)

Explanation of Support:

We applaud and support the following proposed revisions to Part C as advanced by the Department:

- (1) The explicit inclusion of child protective services, foster care, homeless family shelters, and domestic violence shelters as primary referral sources in § 303.303(c)(9)-(11). Making sure that the agencies most engaged with children in the child welfare system have information about Part C and are required to make appropriate referrals is an important recognition that Part-C eligible children in child welfare are not adequately identified and served.
- (2) The explicit inclusion of child protection programs, foster care, State agencies responsible for CAPTA administration, and programs providing services under the Family Violence Prevention and Services Act in the child find system coordination requirements, §§ 303.301(c)(1)(i), 303.301(c)(1)(ii)(G), and 303.301(c)(1)(ii)(I). These provisions properly recognize the important role of those agencies that have the most direct contact with children in the child welfare system and their families..

Conclusion

We greatly appreciate the efforts of the Department in revising the Part C regulations to address the needs of children living in foster care and who are wards of the State. We believe that our proposed recommendations are a logical extension of those efforts and will serve to effectuate the legislative intent of the IDEA to enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the “urgent and substantial needs” of children in the child welfare system.⁵⁹

Very truly yours,

JANET F. STOTLAND
Co-Director

⁵⁹ 20 U.S.C. § 1431(a)(5).

Appendix: Chart of Recommended Changes to IDEA Part C Proposed Regulations

<i>Citation</i>	<i>Proposed Regulation</i>
Statement of purpose § 303.1(d)	The purpose of this part is to provide financial assistance to States to...Enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of all children, including historically underrepresented populations, particularly minority, low-income, inner-city, and rural children, and infants and toddlers in foster care ⁶⁰ <u>and wards of the State.</u>
Definition of at-risk infant or toddler § 303.5 Fallback recommendation if mandatory referral through inclusion in § 302(a)-(b) is rejected	At the State's discretion, <u>at-risk infant or toddler</u> may include an infant or toddler who is at risk of experiencing developmental delays because of biological and environmental factors that can be identified such as low birth weight, respiratory distress as a newborn, lack of oxygen, brain hemorrhage, infection, nutritional deprivation, <u>exposure to dangerous levels of lead paint, and a history of abuse or neglect (including abandonment) of the child or other children living in the home,</u> being directly affected by illegal substance <u>or alcohol</u> abuse or withdrawal symptoms resulting from prenatal drug <u>or alcohol</u> exposure.
Definition of parent § 303.27(a)-(b)	(a) Parent means – (1) A biological or adoptive parent of a child; (2) A foster parent, unless State law, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent; (3) A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State <u>or in foster care</u>); (4) An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or (5) A surrogate parent who has been appointed in accordance with § 303.422 or section 639(a)(5) of the Act. (b)(1) Except as provided in paragraph (b)(2) of this section, the biological or adoptive parent, when attempting to act as the parent under this part and when more than one party is qualified under paragraph (a) of this section to act as a parent, must be presumed to be the parent for purposes of this section unless the biological or adoptive parent does not have legal authority to make health, educational or early intervention services, <u>educational, or developmental</u> decisions for

⁶⁰ Our additions are red, underlined, and in Courier New; our deletions are ~~struck through~~. Provisions marked for support in comments but for no proposed language change are **blue, bold, and in Arial**.

<i>Citation</i>	<i>Proposed Regulation</i>
	<p>the child. <u>The phrase "attempting to act" as used in this Section shall be based on a comprehensive assessment of a person's efforts to act as the parent with respect to developmental, educational or early intervention decisions. Accordingly, a failure to attend a particular meeting or appointment shall be insufficient to preclude a person from acting as a parent under this Section.</u> (2) If a judicial decree or order identifies a specific person or persons under paragraphs (a)(1) through (a)(4) of this section <u>temporarily or permanently</u> to act as the "parent" of a child or to make health, educational, or early intervention service, <u>educational, or developmental</u> decisions on behalf of a child, then the person or persons must be determined to be the "parent" for purposes of Part C of the Act, except that <u>an employee of</u> the lead agency or any other public agency or EIS provider that provides early intervention to the child or any family member of the child, or other child welfare <u>services</u> to the child may not act as the parent. (3) <u>The lead agency shall make every effort to fully include and make all accommodations necessary to ensure that the requirements of the Act are followed with respect biological and adoptive parents of children in foster care or wards of the State, including providing notice and other procedural protections.</u></p>
<p>Assurances regarding early intervention services and a statewide system § 303.101(a)(iii)</p>	<p>The state must provide assurance to the Secretary that – (1) The State has adopted a policy that appropriate early intervention services are available to all infants and toddlers with disabilities in the State and their families, including – (iii) Infants and toddlers with disabilities who are wards of the State <u>or in foster care.</u></p>
<p>Availability of early intervention services § 303.112</p>	<p>Each system must include a State policy that is in effect and that ensures that appropriate early intervention services are based on scientifically based research, to the extent practicable, <u>including approaches specific to the needs of children who have experienced or have been exposed to abuse, neglect (including abandonment), or family violence. These services shall be made</u> and are available to all infants and toddlers with disabilities and their families, including – (a) Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in the State; and (b) Infants and toddlers with disabilities who are homeless children and their families; <u>and (c) Infants and toddlers who are wards of the State or in foster care.</u></p>
<p>Training for personnel § 303.118(b)(2)</p>	<p>Each system...comprehensive system of personnel development...(b) May include--...(2) Training personnel in the emotional and social development of young children, <u>including approaches</u></p>

<i>Citation</i>	<i>Proposed Regulation</i>
	<u>specific to the needs of children who have experienced or have been exposed to abuse, neglect (including abandonment), or family violence.</u>
Public participation policies and procedures § 303.208(a)(1)	Each application must include a description of the State’s policies and procedures that ensure that – (1) Before adopting any new or revised policies and procedures needed to comply with Part C of the Act (including any amendments to those policies and procedures), the lead agency holds public hearings, gives adequate notice of the hearings, and provides an opportunity for comment by the general public, including individuals with disabilities and parents, <u>foster parents and caregivers</u> of infants and toddlers with disabilities
State option to make services available to children ages three and older <u>who experience trauma</u> § 303.211(b)(7)	<u>For all children eligible for part C services, including children ages three and older in</u> In States that adopt the option to make services under this part available to children ages three and older, there will be a referral to the Part C system, dependent upon parental consent <u>of the parent who has been the subject of abuse</u> of a child under the age of three who directly experiences a substantiated case of trauma due to exposure to family violence. <u>Where it is suspected that a child’s parent or caregiver may also be at risk of violence, any referral and/or consent shall be accomplished in a manner to protect the safety and confidentiality of the parent or caregiver who may be at risk.</u>
Traditionally underserved groups § 303.227	The State must ensure that policies and practices have been adopted to ensure – (a) That traditionally underserved groups, including minority, low-income, homeless, and rural families and children with disabilities who are wards of the State <u>or in foster care</u> , are meaningfully involved in the planning and implementation of all the requirements of this part
Public awareness program § 303.300(a)(ii)	Each system must include a public awareness program that provides for --...(ii) Dissemination to all primary referral sources...of the information to be given to parents of infants and toddlers, including especially parents with premature infants, or infants with other physical risk factors associated with learning or developmental complications
Child find system § 303.301(b)(1)(ii)	The lead agency, as part of the child find system, must ensure that – (1) All infants and toddlers with disabilities in the State who are eligible for services under this part are identified, located, and evaluated, including --... (ii) Infants and toddlers with disabilities who are homeless, in foster care, and wards of the State
Programs child find system must be coordinated with § 303.301(c)(1)(i), (ii)(G), (I)	The lead agency, with the assistance of the Council, as defined in § 303.8, must ensure that the child find system under this part – (i) Is coordinated with all other major efforts to locate and identify children conducted by other State agencies responsible for administering the various education, health, and social service programs relevant to this part....Is coordinated

<i>Citation</i>	<i>Proposed Regulation</i>
	<p>with the efforts of the ---.(G) Child protection programs, including programs administered by, and services provided through, the foster care agency and the State agency responsible for administering the Child Abuse Prevention and Treatment Act...;(I) The program that provides services under the Family Violence Prevention and Services Act</p>
<p>Referral of specific at-risk children § 303.302(a)-(b)</p> <p>Primary Recommendation</p>	<p>(a) General. (1) The child find system described in § 303.301 must include procedures for use by primary referral sources for referring a child to the Part C system for – (i) Evaluation and assessment, in accordance with § 303.320; and (ii) As appropriate, the provision of early intervention services, in accordance with §§ 303.342 through 303.345. (b) The procedures required in paragraph (a) of this section must provide for requiring the referral of child under the age of three who – (1) Is involved in a substantiated case of abuse or neglect <u>(including abandonment)</u>; or (2) Is identified as affected by illegal substance <u>or alcohol</u> abuse or withdrawal symptoms resulting from prenatal drug <u>or alcohol</u> exposure; (3) <u>Is identified as having been exposed to dangerous levels of lead paint; or (4) Is identified as having a substantiated case of trauma due to exposure to family violence (as defined in section 320 of the Family Violence Prevention and Services Act).</u></p>
<p>Primary referral sources § 303.302(c)(9)-(11)</p>	<p>(c) As used in the subpart, primary referral sources include ---.(9) Public agencies and staff in the child welfare system including child protective service and foster care; (10) Homeless family shelters; and (11) Domestic violence shelters and agencies...</p> <p><u>(d) Referral of a child under this provision shall occur within ten working days.</u></p>
<p>Screening procedures and notice § 303.303(a)(3)</p>	<p>(3) If the lead agency believes, based on screening and other available information, that the child is not suspected of having a disability, the lead agency must ensure that notice is provided to the parent under § 303.421. <u>If the lead agency is aware the child is in foster care, is a ward of the State, or is under the supervision of a child welfare agency, notice shall also be provided to the caregiver of the child and to the child welfare agency.</u></p> <p><u>(5) The lead agency shall ensure that all infants and toddlers who are referred for screening are subject to re-screening by a qualified professional every six months until age three.</u></p>
<p>Procedures for assessment of the family § 303.320(c)</p>	<p><u>Assessment of the family</u> means identification of the family’s <u>or caregiver’s</u> resources, priorities, and concerns, and the supports and services necessary to enhance the family’s <u>or caregiver’s</u> capacity to meet the developmental needs of the family’s <u>or caregiver’s</u> infant or toddler with a disability, as determined not just through the use of an assessment tool, but through a voluntary</p>

<i>Citation</i>	<i>Proposed Regulation</i>
Confidentiality generally § 303.401(a)	personal interview with the family <u>or caregiver.</u> Each State must ensure that the parent of a child referred under this part is afforded the right to confidentiality of personally identifiable information, including the right to written notice of, and written consent to, the exchange of that information among agencies, consistent with Federal and State laws. <u>In accordance with § 303.303(a)(3), where, based on screening and other information, the child is not suspected of having a disability, and is not referred for a comprehensive evaluation, and the lead agency is aware that the child is in foster care, is a ward of the State, or is under the supervision of a child welfare agency, notice shall also be sent to the caregiver of the child and the child welfare agency.</u>
Insurance and public benefits § 303.520(a)(1)(ii)	The State may use the public insurance or benefits program of a parent or infant or toddler with a disability under this part (consistent with the program requirements of the public insurance or benefits program), if --... <u>(ii) The parent has not provided consent under §§ 303.7, 303.414, or 303.420(a)(3), but the infant or toddler with a disability is in foster care or a ward of the State and eligible to participate in the public insurance of benefits program</u>
Surrogate parents § 303.422	(a) General. Each lead agency or other public agency must ensure that the rights of a child are protected when -- (1) No parent...can be identified; (2) The lead agency, or other public agency, after reasonable efforts, cannot locate a parent; or (3) The child is a ward of the State under the laws of that State. (b) Duty of lead agency and other public agencies. (1) The duty of the lead agency, or other public agency under paragraph (a) of this section, includes the assignment of an individual to act as a surrogate for the parents. <u>The lead agency shall make reasonable efforts to ensure the assignment of a surrogate parent not more than 30 days after a public agency determines that the child needs a surrogate parent.</u> This assignment process must include a method for-- (i) Determining whether a child needs a surrogate parent; and (ii) Assigning a surrogate parent to the child. (2) In implementing the provisions under this section for children who are wards of the State or placed in foster care, the lead agency must consult with the public agency with whom care of the child has been assigned <u>and with any other persons involved in the care of the child, including but not limited to the child's caregiver, appointed guardian, social worker, or attorney, regarding who would best serve as the child's surrogate parent.</u> (c) Criteria for selection of surrogate parents. (1) The lead agency or other public agency may select a surrogate parent in any way permitted under State law. (2) Public agencies must ensure that a person selected

<i>Citation</i>	<i>Proposed Regulation</i>
	<p>as a surrogate parent-- (i) Is not an employee of the lead agency or any other public agency or EIS provider that provides early intervention services or other services to the child or any family member of the child, <u>or child welfare services to the child</u>; (ii) Has no personal or professional interest that conflicts with the interest of the child he or she represents; and (iii) Has knowledge and skills that ensure adequate representation of the child. <u>The lead agency or other public agency shall not remove a surrogate parent based upon a disagreement with the surrogate parent or the surrogate parent's refusal to consent to proposed services.</u> (d) Non-employee requirement; compensation. A person who is otherwise qualified to be a surrogate parent under paragraph (c) of this section is not an employee of the agency solely because he or she is paid by the agency to serve as a surrogate parent. (e) Surrogate parent responsibilities. The surrogate parent has the same rights as a parent for all purposes under this part.</p>