Caring for Children with Special Needs:

THE AMERICANS WITH DISABILITIES ACT AND CHILD CARE
CONTENTS

ADMITTING CHILDREN WITH SPECIAL NEEDS INTO YOUR PROGRAM

WHO IS A CHILD WITH SPECIAL NEEDS?

A child with special needs is one who requires some form of special care due to physical, mental, emotional or health reasons. Children with special needs are also commonly referred to as children with disabilities. **The Americans with Disabilities Act (ADA)** defines a child with a disability more specifically as one who has a physical or mental impairment that substantially limits the child's ability to care for herself or himself, perform manual tasks, or engage in any other "major life activity," such as walking, seeing, hearing, speaking, breathing, or learning, in an age-appropriate manner.

The kind of disability a child might have can vary greatly — allergies, moderate retardation, diabetes, cerebral palsy, or even a terminal illness may each be considered a disability under the ADA. A child with a disability can be one who is visually or hearing impaired, non-ambulatory, has a learning disability, or has an emotional or mental illness. Even a child with a severe behavioral problem whom you or others might regard as having an emotional or mental disability may be protected under the ADA, regardless of whether that child is, or can be, formally diagnosed as having a disability.

Because each child is unique and has unique needs, no single approach to caring for children with disabilities can be applied to all children, or even to those with the same disability. However, you should keep a few basic principles in mind. Children with disabilities are more similar than different from other children. Like all children, those with disabilities should be encouraged to help themselves as much as they can.

You should know that:

- you can integrate many children with special needs into your present program without changes in your routine or physical environment;
- some support services exist to help you care for children with special needs;
- and, best of all, the experience of working with children with special needs can be rewarding for everyone involved, children and adults alike.

IN GENERAL, MAY I DENY CARE TO A CHILD BECAUSE THAT CHILD HAS A DISABILITY?

No. Generally speaking, you may not refuse to care for a child if the reason for your refusal is that the child has a disability. Until Congress passed the ADA in 1990, most providers were under little or no legal obligation to enroll children with special needs or disabilities, and, in fact, many were very selective about which special needs they were willing to care for.

One federal law applicable to some providers before the advent of ADA was Section 504 of the Rehabilitation Act of 1973. However, this law was limited in comparison to the ADA in several respects. First, it covered only programs that received federal monies (for example, from the Child and Adult Care Food Program). Second, few parents of children with disabilities were made aware of their rights under the law and few providers were made aware of their responsibilities. Finally, enforcement of Section 504 in child care has been very weak.

On the state and local levels some laws prohibited discrimination against people with disabilities. Many of these laws were very limited in scope, however, and whether they applied to child care was in some cases unclear. The application of only limited resources to this area made enforcement relatively ineffective in some locales.

Currently, there are federal, state and local anti-discrimination laws in place. After the passage of the ADA, many states and localities used the opportunity to enact or amend legislation concerning the rights of persons with disabilities. In some cases, these laws protect persons with disabilities to a greater extent than does the ADA. And, in the case of anti-discrimination laws, whichever law is the most protective of persons with disabilities is the law that applies. Consequently, the ADA does not trump—or in legal terminology, preempt—more protective state or local laws. To give just one example: under the ADA, a person who invokes the Act's protections must have a disability that "*substantially* limits" a major life activity, but state law in California requires only that the disability "limit" a major life activity.[1] A number of other states, such as Massachusetts and New Jersey, also have anti-discrimination laws that are more protective than the ADA. Therefore, it is critically important that you check your state laws and local ordinances to determine if any of these laws apply to you.

Notwithstanding these improvements in some state and local laws, the ADA remains the first comprehensive law that prohibits disability discrimination by privately owned *public accommodations* nationwide.[2] In addition, Section 504 continues to apply to entities that receive federal funds from programs like the Child and Adult Care Food Program, the Child Care and Development Block Grant Program, and TANF (which may have a different name in your state).[3] Public accommodations, a term that includes private child care facilities, are subject to the requirements of Title III of the ADA, regardless of funding source.[4] This law is very clear about its application to child care programs; the only significant exception is programs operated by religious entities. Importantly, Section 504 does apply to programs operated by religious entities when they receive federal funds.

Child care programs operated by state or local governments (e.g., school districts) must also comply with the ADA. They are covered by Title II of that law, which has requirements that are somewhat different than the Title III requirements discussed in this publication. Private programs housed on school sites are still covered under Title III, and the school district generally has co-existing obligations under Title II. For further information on Title II, see the U.S. Department of Justice website.[5]

THE ADA — WHAT IS ILLEGAL DISCRIMINATION?

Title III of the ADA prohibits public accommodations, including child care programs, from discriminating against anyone who falls within any of these categories:

- **an individual with a mental or physical disability,**
- an individual who has a **history of disability** (e.g., a child with a condition, such as cancer, that is currently in remission),
- an individual who is **regarded as having a disability** (e.g., a child with severe burn scars), or
- an individual who or entity which is discriminated against **because family members, caretakers, friends or other associates have disabilities** (e.g., a child whose parent uses a wheelchair, or whose brother has HIV, as well as an organization serving persons with disabilities. As a result, this provision may also be invoked to prohibit a child care program's landlord from terminating its lease because the program cares for children with disabilities.)

You may not *automatically* refuse to admit a child to your program if your reason is simply that the child, or anyone close to the child, has a disability or is perceived to have a disability. While reasons related to the child's condition may prevent you from caring for the child, the mere fact that a child has a disability, or has a certain type of disability, is not a valid reason under the law to deny the child care. Instead, the ADA calls for a new way of thinking: before excluding a child with a disability from your program, **you must evaluate the child's needs and condition on an individual basis**. Once admitted, each child who has a disability is entitled to **equal, nonsegregated inclusion** in the program offered, to the extent that is appropriate for the child's needs.

Although the ADA was enacted in 1990, the provision that applies to child care programs was not fully implemented until January 26, 1993. Since that date, all child care providers — small and large family child care providers as well as centers — have been subject to being sued if they do not comply with the ADA.

If a provider of any size loses a lawsuit under the ADA, the provider will be required to come into immediate compliance with the law and can be ordered to pay the attorneys' fees of the winning party. In some cases, if the U. S. Attorney General sues for willful, wanton, or reckless violation of ADA requirements, the court may order the provider to pay the family of the child with disabilities monetary compensation for the discrimination, and to pay a public fine of up to $50,000 for the first violation, and up to $100,000 for any additional violations. Thus, the obligations established by this law are clearly ones to take seriously.

MAY I REFUSE TO ADMIT A CHILD WHO HAS A DISABILITY IF I HAVE A WRITTEN POLICY?

No. Prior to the enactment of the ADA, many child care programs had written policies against admitting children with disabilities. Such policies are illegal and will not excuse you from complying with ADA requirements. If your program has such a policy, you should rescind it and remove any reference to it from all of your documents immediately. If you leave the policy intact and you are sued for not admitting a child with a disability, a written policy will most likely serve as an admission of illegal discrimination, even if you had a legitimate reason for excluding that particular child from your program.

HOW DO I DECIDE WHETHER TO ADMIT A CHILD WHO HAS A DISABILITY?

You may not deny care to a child simply because the child has a disability, but you may assess the child's needs and balance them against the size of your program's budget, staff, and other resources. The law is not intended to impose an unreasonable burden on small operations. In fact, many children who are considered to have disabilities under the ADA will, depending on the type and severity of their disability, require very little to accommodate their needs. Often a simple change in activities or limited adult assistance to children whose disabilities are not severe will suffice.

If, based on objective criteria, your program is unable to accommodate the child's needs, you may legally deny care to the child. Generally, a provider may deny care to a child with a disability only for one of five reasons:

1) imposing or applying eligibility criteria that screens out or tends to screen out an individual with disabilities **is necessary for the provision** of the goods, services, facilities, privileges, advantages or accommodations being offered;
2) integrating the child into the program would require ***changes in policies, practices or procedures*** **that would fundamentally alter** the nature of the program ***and*** **there are no reasonable alternatives;**
3) taking the necessary steps to accommodate the child's special needs with added equipment or services to enhance communication (known as "auxiliary aids and services" in the ADA) would impose an **undue burden** on the provider, or would **fundamentally alter the nature of the program or facility**, **and there are no alternative steps that can be taken**;
4) accommodating the child's needs would require architectural changes (removal of barriers) that are **not readily achievable** ***and*** **no reasonable alternatives are readily achievable**; or
5) a particular child's condition would pose a **direct threat** to the health or safety of any of the other children or staff in your program and **there is no reasonable way of eliminating the threat** through changes in policies, practices, procedures, equipment or services.

Denying care to a child under one of these exceptions does not allow a provider to deny care to all children with the same disability. As always, each child's needs must be assessed on an individual basis.

You must attempt to accommodate the special needs of a child with a disability before denying care to that child. For example, you may not refuse care for a child who has a mobility impairment simply for that reason. You must assess the particular child's special needs and attempt to find reasonable means to accommodate those needs. The flowchart in Appendix A will help you understand the assessment process. If the child's mobility impairment is severe, requiring the use of a wheelchair, and if the child has additional functional limitations as well, such as the loss of bladder and bowel control and the inability to feed herself or himself, that child may need special and concentrated attention from a child care provider. A small family child care provider may be unable to give the child adequate care without hiring an additional staff person, which could be an undue burden that would prevent the provider from caring for the child. On the other hand, a child care center with a large enough budget and staff might be obligated to shift around staff coverage or hire extra staff in order to care for that child, as long as the care did not impose an undue burden on the program.

Caring for a child with a less severe mobility impairment, such as one requiring the use of crutches or a leg brace, or even caring for a child who uses a wheelchair but does not require any extraordinary care in addition to accommodating her or his mobility impairment, is less likely to impose an undue burden on a provider of any size or budget. As long as you can integrate the child into your program and reasonably accommodate her or his

needs, you must, regardless of your program's size, admit that child. Furthermore, even if a child's disability suggests that her or his needs may increase over time, you may not speculate about the progression of the child's needs when deciding whether or not to admit the child. If, after admission, the child's needs do change, you can assess the needs again, as frequently as appropriate.

WHAT IS A "REASONABLE ACCOMMODATION"?

When you have to decide whether to admit a particular child with a disability into your program, you will need to assess whether you can care for that child in a way that is not unreasonable for your program. A family child care provider who may not be able to offer reasonable accommodation for a child with a severe mobility impairment may be able to care for a child who uses leg braces by making a few minor program adjustments. It may be possible to integrate the child fully into your program if you simply help the child remove and replace the leg braces when necessary, incorporate activities in which the child can fully participate, ensure that the child's access into and around your home involves as few stairs as possible, and provide adult assistance where needed and other simple forms of accommodation. It is unlikely that any of these measures will be unreasonable, even to a small family child care provider.

Unless changing your **policies, practices, or procedures** or providing equipment or services that enhance communication **(auxiliary aids and services)** would **fundamentally alter the nature of your program or service**, the accommodation will be considered reasonable as long as it does not place the health and safety of others in the program at risk and the equipment or services do not impose an **undue burden** (see below). This is a standard that is difficult to meet. You must push aside any feelings of discomfort, reluctance, or concerns about inconvenience and honestly assess what degree of change and accommodation is possible without stressing your program to the breaking point— i.e., without becoming unreasonable. Because this standard is so high, it is likely that programs of all sizes will be required, under many circumstances, to change their policies, practices, or procedures when necessary to integrate children with disabilities. In the example above, most child care programs, regardless of size, would be able to accommodate the child with leg braces without fundamentally altering the nature of the program. If proposed changes in policies, practices, or procedures would fundamentally alter the nature of your program, you must consider whether any **reasonable alternatives** are available.

An **undue burden** is measured by the particular circumstances of each child care program and is defined by the ADA as a **significant difficulty or expense**. No clear-cut standard determines whether an accommodation would

unduly burden you. Instead, you have to assess each situation as it arises, considering:

1) the nature and cost of the proposed accommodation;
2) your program's overall financial resources;
3) the number of employees in your program;
4) legitimate safety requirements at your site;
5) if a larger corporation owns your program, the overall financial resources, size, and location of the parent corporation; and
6) if the proposed accommodation imposes a significant difficulty or expense, whether **reasonable alternatives** exist that do not impose an undue burden.

If supplying equipment or services that enhance communication (**auxiliary aids or services**) **neither fundamentally alters the nature of your program, nor imposes an undue burden,** then providing the equipment or services would be considered a reasonable accommodation. If a child with a visual impairment needs books in Braille or audio-recorded books in order to participate fully and equally in the program, even many small family child care providers will probably be responsible for furnishing these items. On the other hand, if a child with a hearing impairment needs a full-time interpreter, chances are that accommodating this need would result in an undue burden on a family child care provider, while a larger child care center may be able to accommodate this need. Of course, before a child with a hearing impairment can be denied admission based on undue burden, a provider must explore alternatives to a hearing interpreter that would not be unduly burdensome. For example, with a young child, the provider might learn sign language along with the child. The Individuals with Disabilities Education Act (IDEA) may provide for additional supports in the learning environment such as a notetaker or a sign language interpreter (see the section titled *Does Special Education Offer Any Child Care Assistance for Children with Special Needs?* on page 44 for more information on the IDEA.).

Generally, larger child care programs have greater obligations under the law than smaller family child care programs. While at times it may be a difficult call for you to make, remember that your new responsibilities under this law were not intended to impose on small programs unreasonable requirements that could lead to financial ruin. But they also do not permit you to automatically deny any child admission based on stereotypes or assumptions. Determining what constitutes an undue burden or a fundamental alteration of your program requires a delicate balancing act on your part; you must weigh the needs of the child with the disability against the financial, staff, and resource burden that meeting those needs will entail. Remember that accommodating any disability can involve some degree of added financial or staff burden, but the burden has to be very significant to excuse you from the responsibility of accommodating a child who has a disability. On the other hand, you are not expected to jeopardize the solvency of your program to meet a child's special needs. For each program and each child, this line will be drawn differently.

Sometimes a child's needs can be met only through the **removal of architectural or transportation barriers**. For example, children who use wheelchairs may need to have a ramp built where stairs are in place and may need to have bathrooms made accessible. Barrier removal is only required when it is **readily achievable**, which is a lower standard than the previous two, "**fundamental alteration**" and "**undue burden**." Something is **readily achievable** if it can be done without much difficulty or expense. It is important to keep in mind that whether barrier removal is reasonable should be considered as part of long range planning, rather than waiting for the first child who uses a wheelchair to seek admission. The reason for this is two-fold: first, if changes are not made prior to the first child's application, it will probably be too late, since architectural changes are likely to take more time to complete than other types of accommodations. Second, the cost and inconvenience of making architectural changes may not be readily achievable for many programs if the budget is reviewed in a snapshot manner; however, a greater degree of accessibility is likely to be possible over a longer term. While long-range planning is recommended, programs should still assess children on a case-by-case basis regarding needs that go above and beyond those anticipated through long range planning. For more discussion on architectural barrier removal, see the sections titled *Must I Make Physical Changes to My Home or Child Care Facility?* and *If I Do Make Architectural Changes, Where Do I Start?* on pages 32 and 33 respectively. For more discussion on transportation barrier removal, see the section titled *Must I Make Changes to My Program's Car or Van?* on page 37.

If the arrangements necessary to accommodate a child's needs are costly, the ADA generally requires you to absorb the additional cost to the extent that doing so is reasonable. As a rule, you may not pass the cost of accommodating a child with a disability along to the child's parent(s) unless you increase your fees uniformly for all parents. This means that you would have to absorb the cost of appropriate changes in program, materials, and services that would make your program accessible to a child with a disability if the expense is not unreasonable. If the cost is too great for you to absorb, before you refuse the child care based on this basis you should try to defray the cost by seeking outside funding or free/low cost equipment or services from community resources. Remember, also, that tax deductions and credits are available to help defray some of the costs of accommodating a child with a disability, and you should consider these options before you decide that a particular expense is unreasonable.[6] For more information on surcharges see the section on page 15 entitled *May I Charge the Family More for Serving a Child Who Has a Disability*?.

WHAT IS A "DIRECT THREAT"?

A child care program may deny admission to a child with a disability if it determines objectively that the child's condition would pose a direct threat to the health or safety of the other children or the staff and the threat cannot be

eliminated through reasonable accommodations. Children who have transient short-term illnesses, like the flu or measles, are not considered to have disabilities, and the ADA does not require you to document your decision to exclude them from care while they are sick. But if you believe that a child's disability, meaning a long-term or chronic illness or health condition, poses a direct threat to others, you will have to establish a solid basis for that belief before you decide to exclude the child permanently, and you may exclude the child only as long as the "direct threat" exists.

The direct threat exception is a very narrow one, and the determination is not easy to make. The law requires a provider to base any determination of direct threat on current medical information or "the best available objective evidence." If you believe that a child's condition may pose a direct threat, you should consider:

1) the probable duration of the condition that poses a risk;
2) the nature of the potential harm to others;
3) the severity of the potential harm;
4) the probability of actual harm to others from the particular child's condition; and
5) whether the risk can be eliminated by modifying any policies, practices, or procedures in a way that would not fundamentally alter the nature of the program.

You must consider all these factors in light of currently accepted medical information and knowledge, and not on the basis of public perception or stereotypes. For example, children with HIV or AIDS are *not* considered to pose a direct threat in child care settings if they do not have open, oozing, infectious lesions. In one case, a lawsuit was brought against a child care center that discriminated against a child with Fragile X Chromosome Syndrome. The child's disability caused him to scratch others. However, he was found not to be excludable from the child care setting because the program had failed to try placing gloves on the child, which might have eliminated the potential harm. This case was settled between the parties and therefore does not have the significance of a published opinion, but it does provide some helpful information to those trying to understand the law and its requirements.[7]

Typically, you can get the information you need to make a "direct threat" determination from the child's physician (if the parents consent) or from your program's medical consultants (if applicable), or you can obtain current medical information from a public health agency that publishes up-to-date and reliable information about health concerns. The following agencies may have information that is useful in deciding whether a direct threat exists:

U.S. Public Health Service

Check your phone book under the U.S. Department of Health and Human Services to locate the address and phone number of the regional office nearest you.

Centers for Disease Control and Prevention

by mail:	1600 Clifton Road Atlanta, GA 30333
by phone:	(404) 639-3534 or (800) 311-3435
on the web:	http://www.cdc.gov

National Institutes of Health[8]

by mail:	Allergy and Infectious Diseases Branch Building 31, Room 7A-50 31 Center Drive MSC 2520 Bethesda, MD 20892
by phone:	(301) 496-5717
on the web:	http://www.nih.gov/ http://www.niaid.nih.gov/default.htm

Your local child care resource and referral agency may also be able to provide you with assistance or resources. If you believe that you must deny care to a child who has a disability based on the direct threat exception, you should have documentation from a public health agency or the child's physician backing up your position, and you should keep that documentation in your records.

CAN BEHAVIORAL DISORDERS CONSTITUTE A "DIRECT THREAT?"

Assessing direct threat can be a particularly difficult call to make when faced with a behavioral characteristic or disability. In contrast to infectious diseases, it is not always clear whether a child's behavioral characteristics will pose a direct threat to other children or staff in a child care setting. If a child's special behavioral characteristics suggest that the child requires added supervision that would fundamentally alter the nature of your program, the child's conduct, depending on the severity of the disorder and the risk it poses, may constitute a direct threat.

For some children with behavioral disorders, you can objectively determine the degree of supervision required. For others, a precise assessment may not be feasible. A child who can become very volatile or aggressive may require greater supervision, but it may be very difficult to assess accurately just how much added supervision is necessary without help from parents or professionals.

Remember that, when it comes to determinations of direct threat, the ADA requires you to assess the degree of risk the child's condition poses based on **objective medical information** whenever possible, and to avoid basing your determination simply on your best guess. Therefore, if you feel that a child's behavior may pose a risk, it is very important to approach the parents early on about getting their child's condition assessed professionally. If a child with a behavioral disorder is not under the care of a health care professional, it may become very difficult for you to measure accurately and objectively whether the child's conduct poses a direct threat, and, if so, the amount of added supervision or other special care the child needs in order to eliminate the direct threat. The absence of a regular health care provider may also make it very difficult for you to objectively assess whether you are reasonably able to meet the child's needs.

In cases involving behavioral disorders, you should discuss the child's behavior with the parents and encourage them to seek professional advice on how to meet the child's needs. Of course, the parents are under no legal obligation to do so, but many will be willing if they understand that you are working with them to promote their child's welfare. If the parents agree to seek professional advice, ask them to agree that the health care professional may speak with you to help you assess your program's ability to accommodate their child.

If, after consulting with these individuals, you do not believe that you can provide adequate supervision for a particular child's behavioral characteristics without posing a direct threat to the safety of staff or other children under your care, you may deny the child admission to your program. Remember, this assessment of direct threat must be based on objective information you gather through your consultations and experiences with that child. You may consider the child's behavior a direct threat only if safely accommodating the child's behavioral characteristics would be unreasonable to your program (see Appendix A). For example, if the only way you can adequately supervise a child with a behavioral disorder is to significantly decrease the level of supervision of other children under your care, to the point that their safety is compromised, then you need not shift supervision in this manner.

It is important to recognize that a behavior such as biting, which is demonstrated fairly frequently by typically developing children, is not generally the type of behavior envisioned by ADA's "direct threat" provision. Instead, behavior that could be viewed as a direct threat would not be seen in typically developing children at all or to the extent exhibited by the child in question and the behavior(s) must be assessed in terms of the considerations previously described on page 10.

MAY I ESTABLISH ANY ADMISSION CRITERIA THAT INVOLVE HEALTH CONCERNS?

The law does allow you to establish admission criteria based on health factors, as long as the requirements are uniform for all children and allow for exceptions to accommodate a disability as needed. For example, you may require immunizations, as long as you do so for all children except those who are medically unable to be immunized. But you may not require immunizations for certain children and not others, if the criterion for the immunization requirement is a child's disability.

Similarly, any admission requirements for toilet training should not automatically exclude children whose disability prevents them from becoming toilet trained. You must assess those children on a case-by-case basis to determine if you are reasonably able to care for them. If diapering is offered anywhere in the child care facility, the Department of Justice (DOJ) suggests that it will be reasonable in most cases to offer it to a child of any age who needs diapering due to a disability, even if this means doing the diapering in another classroom. DOJ has also indicated that if diapering is not offered anywhere in the child care facility, you still may not exclude the child automatically, though you may impose a reasonable surcharge on the parents for providing this service.

You may use a child's health or physical or mental abilities as an admission standard only if the child's condition invariably poses a direct threat to the other children or staff. For example, you may exclude a child with AIDS who has oozing infectious lesions for the duration of the lesions, but you may not exclude all children who test positive for HIV/AIDS. Children with HIV/AIDS typically will be considered to have a disability under the ADA, so you may only exclude children whose infectious condition poses a direct threat to others on a casual basis. The child's HIV status is irrelevant in determining direct threat, and any exclusionary policy should be directed to the infectious condition, not the HIV status. Under most circumstances, you should not exclude children from care based on an infectious condition without the recommendation of the child's physician (if you have parental consent to consult with her/him) or the public health department, on a case by case basis. Generally, blanket policies are inappropriate.

Your admission criteria should never screen out or tend to screen out entire classes of disabilities, and you must implement the criteria uniformly regardless of a child's disability status. For example, you may not inquire into a child's HIV status as a criterion for admission, but providing you require the

same information from all children, you may inquire about specific contagious illnesses that the medical community agrees will pose a direct threat to other children. Children with short-term childhood illnesses like measles and chicken pox are always excludable because these conditions are not disabilities under the ADA. A child's HIV status typically is considered a disability under the ADA, and, while some of the conditions associated with the virus may pose a direct threat to others, current medical information indicates that the child's HIV status itself will not. You should always limit your admissions inquiries to health and medical conditions that are directly and objectively relevant to determining the risk to staff and other children enrolled in your program.

It is common for people who have limited experience interacting with children (or adults) with certain disabilities to feel a degree of discomfort at the thought. Education is the best way to deal with ignorance or fear of children with HIV, children who use wheelchairs, children with diabetes, attention deficit hyperactivity disorder (ADHD), asthma, and a variety of other medical conditions. In many instances some training by a professional will dispel any fears or myths caregivers or parents may have about a specific disease. With minimal training, caregivers have learned to feed children with gastrostomy tubes, do finger sticks to check blood sugar levels for children with diabetes and learned to work effectively with children with ADHD. If outside health experts are not available, you can obtain and disseminate printed information about children's disabilities and the importance of inclusive child care. It is advisable to be proactive in these efforts so that staff and parents are comfortable with the idea of including children with disabilities in your program before the need arises.

MAY I CHARGE THE FAMILY MORE FOR SERVING A CHILD WHO HAS A DISABILITY?

As a rule, the ADA prohibits public accommodations from placing surcharges on an individual with a disability or any group of individuals with disabilities to cover the costs of making reasonable accommodations or nondiscriminatory treatment required in order to comply with the ADA. In other words, **you may not pass the cost of any reasonable accommodations you make for a child with a disability along to the parent(s) of that child.** You may however, increase your fees uniformly for all parents in your program in order to offset any additional costs you may have to make these accommodations. On occasion, though, a parent of a child with a disability may volunteer (unsolicited by you) to cover the cost of an accommodation for her or his child if you can reasonably accommodate the child. If this happens, you should inform the parent that she or he is under no legal obligation to

cover the cost if it is reasonable for your program, and you should assess, independently from the parent's offer, whether your program is reasonably able to accommodate the child. If it is, you are still under a legal obligation to cover the cost of the accommodation, regardless of the parent's offer. We suggest that you explain this to the parent and offer to pay for the accommodation.

If, however, after a genuine assessment of the circumstances, you determine that the proposed accommodation would be **unreasonable** to your program and no reasonable alternatives exist, the parent may wish to pay for the accommodation as a last resort, rather than accept denial of admission. Remember, **the parent is not under an obligation to cover the cost** of accommodations that would otherwise be reasonable for you to cover, and ***you should never request*** **that the parent of the child with a disability cover or share the cost of reasonable accommodations.**

Passing costs that would be unreasonable for the program along to the parent is a legally risky arrangement, because whether an accommodation is reasonable is a subjective determination on which people may disagree. You should carefully document your assessment process. Only if you conclude that the accommodation is unreasonable may you assess the parent a surcharge. Always apprise the parent of the decision-making process and considerations prior to proposing a surcharge. If circumstances change later, you may need to reassess whether the accommodations have become reasonable and, if so, whether the program should pick up the cost.

This rule prohibiting you from passing the added cost on to the parents of the child with a disability has two minor exceptions. One relates to providing services of a "personal" nature and the other relates to providing services of a professional nature (other than child care).

The first exception concerns personal services for a child. In child care, this exception is extremely narrow. **In general**, according to the ADA, public accommodations need not provide services of a personal nature, such as assistance with toileting, eating, or dressing, to accommodate people with disabilities unless such services are customarily provided to customers or clients. Because child care by its very nature involves services of a personal nature, the exception that would allow parents of children with disabilities to be charged additional fees for these services is extremely narrow. If you provide feeding, toileting, dressing, and similar services for all of the children in a program, you may not charge a parent of a child with disabilities additional fees for the same service. This is so even if the service is more involved or staff-intensive for that child, unless the added time or staff burden reaches the level of being an unreasonable accommodation.

Even if your program does not otherwise offer a particular type of personal service, such as diapering, the personal service exception that allows you to pass costs to the parent does not always apply. If you do not offer diapering, but you do offer toileting assistance on an as-needed basis, your program may be considered one that offers services of a personal nature involving any

toileting needs. If diapering is offered anywhere in the facility, it is likely that services of this nature will be considered available even in a school-age program housed in the same facility. It is not always clear where to draw the line on personal services, and it is best to assess the reasonableness of offering diapering to a child who cannot be toilet trained due to a disability on a case by case basis. You should not automatically pass along the costs for such services to the parent unless diapering is not offered anywhere in the facility and occasional assistance with toileting is not offered in the program at all. Under no circumstances should you automatically deny care to a child unable to be toilet trained due to a disability.

The second exception to the prohibition of passing on costs to parents concerns non-child care professional services. The ADA does not require a child care provider to provide early intervention or professional services such as occupational, physical, or speech therapy. If the accommodation in question is a professional service that is billed independently from child care (e.g., occupational therapy, physical therapy, or speech therapy), the child care provider need not provide these services as a reasonable accommodation. However, it may be a reasonable accommodation for the child care program to allow the therapist to come to the program to give therapy to the child. What this means is that, if the child can reasonably obtain the service outside of child care and the service is not necessary to integrate the child into your program, but for the sake of convenience the parent prefers that the child receive the service in child care, you will not be responsible for supplying or paying for the service.

For example, if a child in a half-day program needs a daily physical therapy session, and the child's integration into your program is not contingent on it being rendered at your program site, the ADA does not require you to provide the service. On the other hand, services such as sign language interpretation may be necessary for a child's integration into your program, and the program must absorb any costs of providing reasonable services. There may also be instances in which the child care program itself is part of a multi-service agency and can provide extra professional services from its own staff. In this case, the child care program can bill the parent for the child care and the professional services separately.

Certainly your cooperation with parents is encouraged. If a parent requests that services such as physical therapy (paid for by the parent) be provided to the child during child care hours, accommodating this type of request, whenever reasonable, will go a long way in fostering a healthy and trusting relationship between you and the parent of the child with the disability and in some situations may be required.

IF THE CHILD'S SPECIAL NEEDS ARE NOT OBVIOUS, MUST THE PARENT DISCLOSE THEM TO ME?

Parents need not disclose a child's disability or special needs, and you cannot be expected to accommodate any special need that is not obvious or has not been disclosed. Many parents, of course, will volunteer information about their child's special needs in order to secure the best possible care. But some may be reluctant, unwilling, or unable to come forward with information about their child's limitations and special needs. Sometimes the parents themselves have not yet discovered their child's needs or have a difficult time accepting that their child has special needs. In other cases, the parents may be concerned about refusal of care, or about the reactions of other parents. This fear, whether realistic or not, may prevent them from fully disclosing their child's condition.

With many of the more severe disabilities, the child's special needs may be obvious on first impression. But milder disabilities can be less visible. For example, a child with a learning disability, asthma, a compromised immune system, or allergies, may require some special care. Depending on the severity of the disability, unless the child's parents inform you, you may be unable initially to detect the special need. Consequently, in some cases you may not become aware of a child's special need until after you begin providing care. There are, however, some steps you can take to try to minimize the frequency of this happening.

For your protection and that of the child, it is a good idea to request health records of each child in your program. Request health records only for children whom you have already conditionally admitted, and only seek information that is relevant in the child care setting. In California and other states, licensing regulations require centers to obtain health records from each child. While some states may not require family child care providers to obtain health records, this practice is strongly recommended. The ADA allows you to make this an admission requirement, as long as you require records for all children and use the information to assess individual needs, not to screen out children with certain disabilities. These records are likely to inform you of most of the significant health needs of each child. Knowing that the records will be kept confidential will encourage parents to fully disclose information about their child.

Occasionally, a child's health records may be vague or incomplete, either because some of the child's conditions have not yet been discovered or because the parents are reluctant to disclose complete information. It is unlikely that serious conditions known to the health care provider will be omitted, but sometimes information about the child's condition or needs may be masked in medical terms that you find difficult to interpret accurately. This may be especially true when public reaction to a child's condition can involve some

degree of hostility, misunderstanding, or fear, such as when a child tests positive for HIV. Remember, the needs, limitations, and risks the child's condition poses are what are important for you to know. Often the medical diagnosis itself will be irrelevant to you.

If you are concerned that the parents of a child for whom you are considering caring for have not fully disclosed necessary information about their child's special needs, it may be wise to ask them for additional information or clarification. Typically, the information you seek may not be additional medical diagnoses, but rather generic information about the child's limitations, needs, and any risks associated with the child's condition. If you do ask the parents for clarification, you should explain right away why you are asking and explain that they are not required to divulge additional medical information and that you will treat confidentially any information they provide about the child's health. **It is illegal to require additional health tests or information solely for the purpose of screening out or denying care to children with particular types of disabilities.**[9] You may, however, ask for clarification or details concerning the child's special needs for care, as long as you are seeking the information to evaluate whether you are reasonably able to care for the child, and, if so, to provide the best care possible.

You should explain these rules up-front to the parents and try to create an atmosphere of trust with them. In the end, if the parents understand that their child is not in danger of being prejudicially denied admission into your program, nor is there danger of public disclosure of their child's condition, the parents are far more likely to be willing to give you supplementary information about the special care their child needs.

WHAT ARE UNIVERSAL INFECTION CONTROL MEASURES?

Because some parents may still be reluctant to disclose a child's health status fully, and because a child may have a health condition that is not yet discovered, it is very important to use universal infection control measures on a regular basis. This will also help you treat all children alike.

Universal infection control measures are a set of simple hygiene, social, and behavioral guidelines recommended by the Centers for Disease Control and Prevention and the American Academy of Pediatrics to prevent the spread of infections. Since 1992, most child care providers have been required by law[10] to establish and practice a set of infection control guidelines. The best way to control the spread of any infection in a child care setting is to implement these guidelines uniformly and adhere to them strictly. While these universal precautions are designed to prevent the transmission of HIV, HBV (hepatitis B virus),[11] and other infections, **they will be effective only if you practice them**

on a consistent basis, regardless of whether a particular child or adult is known to have an infectious disease. All child care programs, whether legally required to or not, should follow the uniform guidelines. Doing so will greatly reduce the risk of transmission of infection in your child care program and may serve to protect you from liability should a child under your care contract an infectious disease.

Generally, universal precautions entail relatively simple precautions that many child care providers already practice. Moreover, most recommended or required precautions are neither expensive nor difficult to implement. They include regular hand-washing, daily cleaning of surfaces, use of latex gloves when coming into contact with blood or blood-containing body fluids, and proper disposal of items that can potentially carry infectious material. To ensure uniformity in universal precautions, you should formally adopt a set of written guidelines that becomes standard procedure. To determine whether your program is required by law to comply with universal precautions, and for a detailed description of the universal precautions required by law and recommended by the CDC, see the section titled Universal Precautions and OSHA Regulations below.

UNIVERSAL PRECAUTIONS AND OSHA REGULATIONS

WHO IS REQUIRED TO ESTABLISH UNIVERSAL PRECAUTIONS?

Providers who employ any permanent or temporary, full-time or part-time staff or substitutes, or who use volunteers who receive free meals or other in-kind compensation, are required by law[12] to adopt a written policy for universal precautions that conforms at least minimally to the guidelines set forth in this publication. Even small family day care providers who are exempt from this law should make serious efforts to adopt guidelines and practices that conform minimally with these recommendations, as a means of protecting your program legally and protecting the health of the children and staff. Aside from the instructions and guidelines you can obtain from OSHA, your local resource and referral agency may have resources helpful to you in developing your infection control guidelines. Other resources that may help you can be found on pages 45-50.

WHEN IS HAND-WASHING NECESSARY?

Whether or not gloves are used, hands should always be washed immediately after handling body fluids. If any other body part (like bare arms) comes into direct contact with blood or a blood-containing body fluid, that skin should also be washed immediately after contact. The washing, of course, will

also help to prevent the transmission of many other infections, and should be done regardless of whether the body fluids handled contained blood.

Hand-washing is critically important. It is the best method for preventing the spread of many infections — not just HIV and HBV — in the child care setting. Hand-washing should always be done under the following circumstances:

By adults:
- after diapering a child,
- after wiping a child's nose,
- before preparing or eating food,
- after using toilet facilities,
- after coughing, sneezing, or blowing their own nose,
- before and after treating and/or bandaging a cut,
- after being in contact with any other body fluids from another person, and
- after cleaning toys, wiping down surfaces, cleaning spills, or any other housekeeping.

By children:
- before preparing or eating food,
- after using toilet facilities,
- after being in contact with any other body fluids from another person,
- after blowing their own nose,
- before doing group projects involving contact with food.

Frequent hand-washing may cause dry and chapped skin. In order to prevent new breaks in the skin due to dryness, it is a good idea to provide hand lotion near the hand-washing area. Cuts and breaks in the skin increase the risk of HIV and HBV transmission if they come into direct contact with infected blood or blood-containing body fluids.

WHAT IS THE PROPER METHOD OF HAND-WASHING?

The proper method for hand-washing is to turn on the faucet, wet, and then lather the hands well using water and bar or liquid soap.[13] Rub your hands together for ten to fifteen seconds, cleaning the palms, tops of the hands, between the fingers, the wrists, and under the nails. Rinse hands well under running water, and dry with a disposable paper towel. Use a paper towel to shut off the faucet.

DO I EVER NEED TO WEAR LATEX GLOVES?

Child care providers should take two main precautions to prevent the transmission of HIV and HBV:[14]

- avoid direct contact with any blood, regardless of its source; and
- adopt hand-washing as a regular habit after handling any body fluids.

Direct contact with blood can be avoided under most circumstances by using disposable latex gloves when handling any blood-containing body fluid. Remember, using gloves will not only protect you from the virus, but also will prevent the spread of the virus from child to child through you or the gloves. Always dispose of gloves immediately after use, and never use them for handling more than one child. If gloves become torn or punctured while in use, dispose of them immediately. After you wash your hands, put new gloves on before continuing to handle blood or blood-containing body fluids.

Proper disposal of gloves means ensuring that no child or adult comes into direct contact with them. Gloves should be disposed of in a container with a firmly closing lid. Because used latex gloves that came into contact with blood or blood-containing body fluids are generally considered regulated waste under OSHA regulations, the disposal container should be red, lined with a red plastic bag, or labeled with the words or symbol for BIOHAZARDOUS WASTE (see Appendix B for a reproduction of the biohazardous waste symbol). Using a red container or liner is called color coding under the OSHA regulations. Some states, like California, require both color coding and labeling. Federal law allows you to choose between color coding or labeling. Check your state OSHA office to find out the waste management requirements for bloodborne pathogens in your state. If the state regulation requires more than the federal regulation, like it does in California, you must comply fully with the state regulation.

You must use a liner in your regulated trash receptacles, regardless of the liner's color, and the entire liner should be removed each time you empty the receptacle. Check with medical supply stores or your local hospital on how and where to obtain the red garbage bags or receptacles. See section titled *What Precautions Should I Take in Waste Disposal?* on page 24 for a more extensive discussion of disposal of regulated waste.

Individuals with latex allergies or sensitivities to latex should not use or be exposed to latex gloves (i.e., co-workers of latex sensitive individuals should not use powdered gloves). A variety of non-latex gloves now available on the market are just as effective and should be used instead.

SHOULD I WEAR GLOVES WHILE DIAPERING A CHILD?

According to the CDC, gloves are not generally necessary when changing diapers. Although trace amounts of HIV or HBV may be present in urine and feces, those body fluids have never been known to transmit the virus.

However, gloves should be worn under certain circumstances:

- if the child is experiencing bloody diarrhea;
- if the child's stool is bloody;

- if the child has a bloody diaper rash; or
- if the provider has open lesions, cuts, or breaks in the skin on her or his hands.

Whether or not you use gloves, you should wash your hands, and the child's hands, after each diapering, according to the hand-washing policies outlined above.

Once a dirty disposable diaper is removed from a child, it should be placed immediately in a diaper receptacle. Diaper receptacles should be plastic garbage cans with tightly closing lids that are lined with disposable plastic bags (red bags or red receptacles with liners, or ones labeled with the words or symbol[15] for BIOHAZARDOUS WASTE should always be used for diapers that have blood on them. Check your state regulations for the exact requirements for color coding or labeling applicable for you.). Place dirty cloth diapers first in a plastic bag designed for diaper disposal that can be securely tied, and then place the bag in a diaper receptacle. Use separate diaper receptacles for disposable and cloth diapers. To empty the disposable diaper receptacle, remove the entire plastic liner and fasten it securely. Send dirty cloth diapers home, in their plastic bags, with each parent or guardian at the end of the day.

Locate diaper receptacles away from the children's play areas and away from food preparation and serving areas. Clean them on a daily basis, and, if blood-containing body fluids come into contact with any receptacle, clean it immediately with bleach solution while wearing latex gloves.

SHOULD I WEAR GLOVES IF A CHILD IS INJURED?

If a child under your care is injured and the injury involves a bleeding wound, you should wear gloves when caring for the injury, particularly if you have open sores, wounds, or chapped skin on your hands. Once the wound has been dressed, you should remove and dispose of the gloves and wash your hands as outlined above.

If a child or staff member is injured badly and is bleeding profusely, you may not have the time or opportunity to put on additional protective clothing. In that case, if blood soaks through any of your clothing, remove it as soon as possible, place it in a red garbage bag, and launder it separately from other clothes. Treat any blood soaked towels or other cloth items the same way. Wear disposable gloves when laundering blood soaked clothing or bandages. Of course, all skin that comes into contact with the blood, either directly or through clothing, should be washed immediately.

WHAT CLEANING PROCEDURES SHOULD I FOLLOW? WHAT CLEANING SUPPLIES DO I NEED?

Because we know that HIV and HBV can be inactivated easily with diluted solutions of household bleach, experts recommend using a bleach

solution as an economical disinfectant. It is a good idea to always have some pre-mixed bleach solution on hand, so that accidents and spills can be cleaned up right away. Mixing the solution in a spray bottle will simplify the cleaning process, allowing you to spray the solution on surfaces as needed.

The basic solution that experts generally recommend consists of one part chlorine bleach to sixty-four parts water. You may make the solution stronger than this if you choose, or if your state law requires it, although this solution will generally be strong enough under most circumstances. Some state laws, though, may have very specific disinfectant requirements. You will need to check with your state OSHA office to find out if this basic bleach solution is sufficient, or if your state law requires a different or stronger solution. If you use a bleach solution, it must be prepared daily to retain its disinfectant power, so you should not prepare a great deal more than you anticipate needing for a day's cleaning. Depending on how much of the solution you choose to prepare, the following measurements are a basic guideline:

One quart of solution:
Add one tablespoon of bleach to one quart of water.

One half gallon of solution:
Add one eighth cup bleach to two quarts of water.

Regular housekeeping should include daily cleaning of all surfaces and the children's play areas by spraying on the basic bleach solution and scrubbing the area well with a cloth or mop. Rinse the surfaces well (optional) and allow them to air dry. All mops and cloth towels used in cleaning should be disinfected in a bleach solution or laundered. Store and wash laundry that has come into contact with potentially infectious body fluids separately from the other laundry, and only handle it if you are wearing latex gloves. Store these items in a red, closable garbage bag or receptacle until you can wash them.

Clean the diapering area after each diapering. Use a paper towel to clear the surface of any urine or feces with a paper towel; then spray with the bleach solution. Allow the area to air dry or wait two minutes before wiping dry.

A surface that has had body fluids on it (blood, urine, feces, saliva, nasal fluid, etc.) should be wiped off as soon as possible with disposable towels. If the body fluid contained blood, you should put on latex gloves before you begin to clean. Once the fluid has been wiped up, you should cover the surface with the bleach disinfectant and let the surface air dry.

All trash containing items that may have come into contact with potentially infectious body fluids, like bloody diapers, dirty disposable gloves, and paper towels used for cleaning and spills, should be securely tied in the plastic bags that are used as liners for your indoor trash receptacles (receptacles containing these items should have securely closing lids). Federal regulations require either that the bag or the trash receptacle be red, or that the trash receptacle be labeled with the words or symbol for BIOHAZARDOUS WASTE

(see Appendix B for a reproduction of the symbol). Check with medical supply stores or your local hospital on how and where to obtain the red garbage bags or receptacles. California regulations require both color coding of the bag or receptacle and labeling of the receptacle. Check your state regulations, if applicable, for possible variations on this requirement.

DO I NEED TO CLEAN TOYS THAT THE CHILDREN ARE SHARING? WHAT IF THE CHILDREN ARE MOUTHING THE TOY?

It is recommended that toys used by infants and toddlers be washed daily. If children are drooling on or mouthing the toy, it should either be used by only one child or washed before it is given to another child to play with. While this recommendation may not always be realistic, you should make particular efforts to follow this guideline if you know that a child has open sores in her or his mouth, is teething, or is bleeding for some other reason. In some cases, you may find it helpful to start off the day using a limited number of toys that you can replace later in the day when the original toys become mouthed and dirty.

The most effective method of cleaning a toy is to submerge it in a bleach solution and then submerge and agitate in clean water to rinse (rinsing is optional). Toys may be dried in the open air (in a net bag) or with paper towels. Many toys can also be washed in a dishwasher.

WHAT PRECAUTIONS SHOULD I TAKE IN WASTE DISPOSAL?

It is important to emphasize proper waste disposal. While HIV or HBV infection is extremely unlikely to occur in a household or child care setting, remember that these precautions will serve to shield you, your staff, and the children you care for from a vast array of possible infections. While wearing gloves, hand-washing, and regular cleaning practices are vital first steps in reducing the likelihood of infection, waste disposal is the remaining part of the formula, and just as vital as the other steps. It is important to protect not only the person who is doing the housekeeping, but also the children who may be tempted to explore the garbage. In addition to the guidelines set out above for waste disposal, the following steps are important:

• If injections are administered to any child in the program (for example, if you are caring for a diabetic child who requires regular injections), do not re-use, recap, or break off the needles. Dispose of contaminated needles immediately after use in a closeable, puncture resistant, leakproof, red container (usually the parents can obtain these containers from the treating physician or a pharmacy). Store the container out of reach of the children, but make it easily accessible to the staff who administer the injections. Once needles are placed in the

container they should never be removed manually; the container must be discarded intact. Close the container securely when you discard it. To discard, it is preferable to have the parent return the intact container to the treating physician and pick up a replacement container for you.[16]

• Waste receptacles in bathrooms should be plastic, lined with plastic garbage bags, and have a securely closing lid if you use them to dispose of any blood-containing articles or any cleaning towels. Remove the garbage bags each time you empty the receptacles, and replace the bags with new liners. Close bags securely before discarding. Sanitary napkins and tampons should be discarded only in this type of receptacle. The liners or the receptacles should be color coded red or labeled with the words or symbol for BIOHAZARDOUS WASTE (or both, depending on state law).

• Every day, clean garbage cans, diaper receptacles bathroom wastebaskets, or other containers that are reasonably likely to come into contact with blood or blood-containing body fluids; also clean them immediately after contact with a potentially infectious body fluid.

• Line all receptacles likely to contain articles with squeezable or caked on blood with plastic bags, and empty them only by removing the entire liner. The liners or receptacles should be color coded red, or labeled with the words or symbol for BIOHAZARDOUS WASTE. In some states, including California, both color coding and labeling are required. Check with medical supply stores or your local hospital on how and where to obtain the red garbage bags or receptacles.

• Depending on state or local laws, you may not be able to dispose of the red bags through your regular garbage pick-up. California has special laws limiting how and by whom red color coded bags may be removed, and these laws prevent most trash collectors from removing them with the unregulated waste. Check with your waste disposal company, and if the law does not permit them to pick up the red bags, find out from them, a child's treating physician, a child care health consultant, or a local hospital how to dispose of the red garbage bags containing biohazardous waste. Unfortunately, in most places, you will have to arrange a special pick-up for the red plastic bags. In states where you have a choice, the advantage to using red plastic liners is that you do not have to color code your trash receptacles. The clear disadvantage is the added expense of purchasing and disposing of the red liners. In states where you have to both color code and label, you may still be able to avoid using the red liners by color coding your receptacle, rather than the liners.

• Broken glassware or other materials that caused a child or staff member to bleed must not be picked up manually. Use a dustpan and broom or brush, or tongs.

DO I NEED SPECIAL TRAINING?

Because caring for a child with special needs is always an individualized matter, and most disabilities are not severe, special training is often unnecessary. Much of what you need to know you will learn as O.J.T. — On-the-Job Training. Of course, some of the disabilities or special needs you encounter may be more challenging than others, and you may find training and other resources to be very helpful, or even necessary. If caring for a child requires training, you may not automatically deny care to a child simply because you currently lack adequate training. Again, you will need to determine whether training is reasonably available (geographically, financially, and time-wise, as well as whether you or your staff qualify for the training), or whether obtaining the training would **fundamentally alter the nature of your program or would impose an undue burden**. As with other types of accommodations, you must make decisions about obtaining adequate training to care for a child on a case-by-case basis, taking into consideration the child's individual needs and the reasonableness to your program of obtaining training.

As a caregiver, advice, assistance, and training are available to you from many sources at low or no cost, including:

- **Parents** — share your observations with them; consult them; stay in close contact with them. They can also refer you to community agencies they have found.
- **Resource and Referral Agencies** sometimes have specialists or can refer you to appropriate community agencies. Many of them also offer periodic trainings for providers, along with public health and special needs resources and materials. Many resource and referral agencies have a copy of the recently published Caring for Our Children, National Health and Safety Standards: Guidelines for Out-of-Home Child Care Programs, a joint project of the American Public Health Association and the American Academy of Pediatrics. Resource and referral agencies with this comprehensive guide will be able to give you current information and guidelines for many of your questions.
- **Community agencies** offer services designed to meet the special needs of these children (for suggestions, see pages 46-50).
- **Community colleges** offer classes and trainings on child development, special needs, and health and safety.
- **Health resources** offer up-to-date medical information, guidance, and recommended care for particular disabilities, to help you decide whether you are reasonably able to admit a child with a disability, and information on how to care for and integrate the child safely into your program. One such resource in California is Healthline, a toll-free phone service that can be reached at 800-333-3212. Many states, including California, have child care health consultants available to advise child care providers on a variety of health and disability related

issues. Contact the American Academy of Pediatrics (http://www.aap.org) to learn more.

- **Books —** read as much as you can about the child's disability (for suggestions, see the list titled *Are There Books and Resources to Help Me Learn More About Children with Special Needs?* on page 45) , but also take direction from the parent.

DO I NEED A SPECIAL LICENSE?

Requirements vary from state to state, but in California you will not need a special license to care for children with disabilities, even if all of the children you care for have disabilities. A family child care or child care center license will allow you to take care of children, whether they have special needs or not.

However, in order to care for non-ambulatory children[17] in California, the space you use for child care must be approved for these children by the local fire inspector and licensing agency. And because the ADA requires you to care for children with disabilities in an integrated manner with the other children, caring for non-ambulatory children means that all the space you use for child care will need to be approved. You may not use separate spaces for ambulatory and non-ambulatory children.

If the space you currently use is not already accessible and approved for non-ambulatory children, and a non-ambulatory child applies for admission, the ADA requires you to take **readily achievable** measures to make the space you use for child care accessible.[18] Of course, for many programs on a tight budget, making your facilities accessible may take time. If you are not already caring for a non-ambulatory child, but making your child care space accessible to non-ambulatory children can be reasonably done over time, it is wise to plan ahead and ready your facilities for the day a non-ambulatory child applies to your program. Planning ahead and preparing the facilities for non-ambulatory children will ensure your ability to comply with the law promptly and will prevent unnecessary delays when a non-ambulatory child applies for care. Check with your local fire inspector for non-ambulatory accessibility requirements before you begin your renovations, so that your renovation plans can conform to the non-ambulatory fire clearance requirements.

If removing barriers over time would have been readily achievable but your program failed to initiate the renovations until a non-ambulatory child applied, the delay that this failure causes may place your program in violation of the ADA. On the other hand, if you have a plan in place and are making good faith efforts to make the facility accessible within a reasonable time frame, you will likely be fulfilling your ADA obligations even if you are not able to complete the renovations in time to admit the first non-ambulatory child who applies. Remember that if it is readily achievable to speed up renovations in order to accommodate a particular child, the ADA will require this of you, regardless of your long-term plan.

If a child's care involves special health procedures, additional considerations may be involved.[19] In a number of states, laws defining the scope of responsibilities for health professionals may limit who may perform certain health procedures. In other states, like California, child care programs may provide only "non-medical" care under the current licensing laws. Some states simply require documentation of an agreement between the treating physician, parent, and provider. A few exceptions to California's rule have been or are currently being established. For example, Epi-Pen™ injections for emergency treatment of children with severe allergies are now permitted in child care in California, as are inhalers and nebulizers for children with asthma. It has also been determined that child care providers may feed children through the use of gastrostomy tubes and engage in blood glucose testing for children with diabetes.

Aside from limited exceptions, a program that delivers any "medical" care would violate the California licensing laws. This is problematic in light of ADA requirements that suggest an obligation for child care providers to care for children who may need special health procedures administered to them while in child care. Considering child care's new responsibilities under the ADA, these state licensing laws are currently under review, and are likely to be further revised to eliminate unnecessary barriers that might otherwise discourage or prevent child care providers from caring for children with disabilities. State licensing laws that create barriers to provider compliance with the ADA are being challenged through litigation in several states, and these cases are likely to provide further guidance.

If you are outside California, check with your state licensing agency for applicable licensing requirements.

ACCOMMODATING A CHILD WITH WITH SPECIAL NEEDS

IF I ADMIT CHILDREN WITH SPECIAL NEEDS INTO MY PROGRAM, WHAT KINDS OF ACTIVITIES CAN THEY PARTICIPATE IN?

Children with special needs are entitled to participate as equals with other children in **"the most integrated setting appropriate to the needs of the individual."** You must allow a child with a disability to participate in your program in a manner that is equal to, and not separate from, the program you offer to the children without disabilities, **in all matters of program, privileges, advantages, accommodations, and facilitie**s. It will not be necessary to change your program significantly to accommodate many children who are considered to have a disability under the ADA. If it is impossible for a particular child with a disability to participate fully and equally, you will need to examine the barriers to that child's participation. If you can integrate that child in your program through changes in your policies, practices, or activities that would **not fundamentally alter the nature of your program or facility**, the law requires you to make the changes that will accommodate the child's needs (see Appendix A).

To determine what is appropriate, you must look to each child's unique needs and abilities. What is the child able to do? What are the child's limitations in activities? What can the child comprehend? What assistance does the child need? What can the child use to allow participation in an activity? Under what circumstances is the child's safety uniquely at risk? You will need to answer these and many other questions to assess what is appropriate. Generally, consulting with the child's parents and physician, public health officials, and/or other special needs resources in your community may help you determine whether the program you offer is appropriate for a particular child, or whether you need to make some modifications to accommodate that child.

Child care providers may need to buy specially adapted toys as a reasonable accommodation for a child with a disability who is attending their program. For example, you may need to buy books with large print or Braille as a reasonable accommodation for a child with a vision impairment or purchase puzzles with large handles on the puzzle pieces so that they are easier to grasp. Other examples of adaptive equipment and toys might be to provide a special feeding bowl or enlarge the handles of utensils, markers, pencils or toys by wrapping foam or masking tape around an existing handle for a child

with physical disability. Also, see the section entitled *Must I Provide Any Special Equipment in Order to Ensure Effective Communication for a Child Who Has a Disability?* on page 38 for a discussion of the provision of special equipment (auxiliary aids and services) when necessary for effective communication.

IF A PARENT DOES NOT VOLUNTARILY DISCLOSE THE CHILD'S DISABILITY OR SPECIAL NEEDS TO ME, HOW DO I CARE FOR THAT CHILD?

With genuine effort on your part to foster a safe, trusting environment, you will probably find that most parents will want to discuss their child's special needs openly with you, in order to obtain the best possible care. Some parents, however, may still hesitate to identify their child as having a disability or to discuss their child's special needs in detail, despite your best efforts. These parents may feel particularly protective or cautious for their child and may have very real experiences of discrimination, ostracism, hostility, ignorance, fear, or other adverse reactions directed at their child. If their experiences have elevated their anxiety level, your inquiries about accommodating the child's special needs may go unanswered. Parents are under no legal obligation to provide this information to you.

Other parents may not be ready, themselves, to accept their child's disability, whether physical, mental, or emotional. Certainly, those parents are also unlikely to be forthcoming with supplementary information about their child's needs, particularly since they may have very little comprehension or awareness of the needs themselves. In such situations, the parents may not only be unable to give you supplementary information about their child's needs; they may actually fail to see any need for special care you might recommend. In these cases, it is a good idea to document your attempts to obtain additional information and the parent's refusal to provide such information.

Cases involving initially unidentified disabilities, needs, or accommodations are likely to arise now and then, and many of them probably will not pose an insurmountable problem. You will be able to handle most of these situations simply by dealing with the obvious as it arises. In many cases, if a child has an evident disability, whether the parents cooperate or not, you will be able to identify needed accommodations through general consultation with a local public health official or other resource, many of which are listed in this publication. If the parents are cooperative, you should also consult with them or (with the parents' consent) the child's physician.

If a disability is not obvious to you and the parents do not disclose the child's limitations and needs, you are under no legal obligation to

accommodate the disability unless you *regard* the child as having a disability based on your own observations (see section titled *The ADA – What Is Illegal Discrimination?* on page 5). If the parent wants the child's need to be accommodated, it is the parent's duty to disclose any need for accommodation that is not self-evident. But, while you are under no legal obligation to accommodate special needs of which you are not aware, you may not refuse care solely because a child's special needs have not been disclosed to you.

Occasionally, after you begin caring for a child, you may become aware that the child has special needs and feel ill-equipped to evaluate them. If the parents do not support your observations or cooperate with your efforts, you may be placed in an awkward position if you believe that expert assistance is necessary to help you identify or care for the child's special needs. This can be particularly true with behavioral disorders or mental or emotional disabilities. In these cases, you may be under no legal obligation to provide special accommodations if a child's parents are not willing or able to give you information about the child's needs or to have their child professionally evaluated. If you are able to care for the child safely and appropriately with or without providing special accommodations, you still have a legal obligation to care for that child as you would any other.

In extreme cases, a parent's failure to discuss a child's disability or special needs with you may make it too difficult or even impossible to provide safe, appropriate care for the child with the disability as well as for the other children under your care. For example, you may care for a child whose behavior is extremely disruptive and aggressive, to the point that you believe that the child requires a behaviorist with whom to work, as well as additional supervision. The child's behavior may not be too difficult for your program to accommodate if the parents agree to have the child evaluated and obtain professional recommendations for handling the child's behavior. Without the parents' cooperation, however, accommodating the child may become unreasonable, and you may not be able to care for the child, for two reasons:

1. **It is not your legal duty to aggressively discover or evaluate a child's special needs.** Unless a child's needs and the accommodations they require are self-evident, it is the parents' responsibility to give you the information necessary to accommodate the child's special needs if they expect the program to care for their child. If you are unable to provide safe, adequate care for the child without offering special accommodations, like added supervision, then you are legally required to care for the child only if you can accommodate the child's special needs. If you are unaware of particular needs and/or the means to accommodate them, (having tried common sense approaches) provision of care is no longer required. In some cases, safe and adequate care is likely to require some professional guidance and assistance, which you may have no way of obtaining without the parents' direction and cooperation.
2. **You must consider the safety and well-being of the other children.** Lack of professional recommendations regarding appropriate care for a child

with aggressive and disruptive behavior may jeopardize the safety and adequate supervision of all the children.

In either of these situations, it is critically important to document exactly what has transpired. In any case in which caring for a child with a disability or special need, previously disclosed or not, becomes unreasonable to your program, you are no longer under a legal obligation to care for the child. Remember, though, that most children with undisclosed disabilities will be no more difficult to care for than children with disclosed disabilities, or with no disabilities. The ADA requires you to take reasonable steps to care for these children and to accommodate any needs arising out of a disability of which you become aware, or of any condition you regard as a disability.

MUST I MAKE PHYSICAL CHANGES TO MY HOME OR CHILD CARE FACILITY?

If a child with a disability applies to a child care program, it is the provider's responsibility to remove existing barriers to the accessibility of her or his home or facility wherever this is **readily achievable**. Readily achievable means "**easily accomplishable and able to be carried out without much difficulty or expense**."[20] For example, if you are a family child care provider and your front door can only be reached by climbing a flight of steps, but your side door is at ground level, making the side door into an accessible entrance to your home is readily achievable, even if this involves clearing the side walkway of toys, lawn furniture, weeds, overgrown brush, and any other obstacles to a wheelchair. If the walkway to the side door is not smooth or level enough for a wheelchair, you may also need to take readily achievable measures to remedy that. And if that side door is one step up from the ground, supplying a portable wooden or rubber ramp, or adult assistance in climbing that step will also probably be readily achievable. On the other hand, due to the cost of installation, building a permanent ramp to the front door may not always be readily achievable, particularly for small family child care providers.

Certainly, not all child care providers are excused from building permanent wheelchair ramps, but many family child care providers, and even some small child care centers, are likely to be. Generally, under the ADA, a provider need not make physical changes to her or his home or child care facility if doing so would involve more than a fair amount of difficulty or expense. The program's relative size and budget determines whether something would be considered expensive or difficult; the key is reasonableness. If building a ramp is not readily achievable, you still have a legal obligation to examine **reasonable alternatives** to accommodate the child, and to remove barriers to accessibility wherever doing so is readily achievable (see Appendix A). Each time a child with a disability applies to your program, you will need to assess what that

child needs, whether your home or facility contains barriers to that child's access to your care, and whether any readily achievable options would enable you to meet that child's needs.

IF I DO MAKE ARCHITECTURAL CHANGES, WHERE DO I START?

If you are a family child care provider, removal of barriers in your home, wherever readily achievable, is required only in those parts of your home that you use either partially or exclusively for child care. Any new construction or additions to a child care facility or home that are intended to be used for child care must be accessible, regardless of expense.

If you do make changes to your home or child care facility to make it more accessible, you should do so in the following order:[21]

1) make at least one of your exterior entrances accessible (install ramps, widen doors, etc.);
2) make your program areas more accessible (remove high-pile, low-density carpeting, widen doors, install accessible door hardware, etc.);
3) make your bathrooms more accessible (widen doors, install grab bars, provide a raised toilet seat, etc.).

Some cities may have ordinances that require more than the ADA and require that child care facilities be made accessible to people with disabilities. Facilities located in a city with one of these ordinances may be required to build a wheelchair ramp unless there is at least one ground-level entrance. If you are not reasonably able to do so, the city may waive this requirement upon request or allow you to accommodate children with disabilities through alternative means.

If you are required to build a ramp or make other modifications, or if you choose to do so in order to better serve children with special needs, government funds or tax benefits described below may be available for this purpose.

Specifications for modifications in compliance with the ADA can be found in the ADA Architectural Guidelines (ADAAG); these are available from the Architectural and Transportation Barriers Compliance Board (ATBCB) — see the resource list beginning on page 45 for the address and phone number. The ATBCB has also issued recommended guidelines for child-size modifications, separate from the ADAAG. These guidelines do not yet have the force of law but provide the best current expertise on this subject.

MUST I MAKE CHANGES TO MY PLAYGROUND?

As stated above, child care centers and family child care homes must remove all architectural barriers if possible, and if not must try to make their services and facilities available through alternative methods. For child care facilities, another space that must be made accessible is outdoor play areas. The Architectural and Transportation Barriers Compliance Board (Access Board) has a set of guidelines called the Americans with Disabilities Act Accessibility Guidelines, or ADAAG. These guidelines are final but not yet adopted by the Department of Justice so they do not have the force of law. Nonetheless, they are well worth following, as they are the best thinking on this subject, will provide a safe harbor between now and when guidelines are adopted, and will serve as the basis for the enforceable standard. Section 15.6 of ADAAG addresses accessibility requirements for new or renovated outdoor play areas for children over two in child care centers. It is important to remember that the ADAAG are *minimum* guidelines and that additional designs and features not mentioned in the ADAAG may further enhance the accessibility of your playground.

Family child care homes do not have to comply with Section 15.6 of the ADAAG. However, play areas in family child care homes must be accessible to the extent that such accessibility is *readily achievable*, that is, "easily accomplishable and able to be carried out without much difficulty or expense." This applies even when family child care providers are altering their play areas or constructing new ones. The rest of this section will discuss the requirements for child care centers.

Child care centers have more responsibilities than family child care homes. In existing play areas where no construction is planned, child care centers must remove all architectural barriers that prevent the use of play components by children with disabilities if removal would be "*readily achievable*." The meaning of this term depends on how difficult and expensive the change would be and how much money is available to the child care provider to make the change. What is "readily achievable" will vary from one child care center to the next, so each child care provider will have to determine what is readily achievable under the circumstances.

When child care centers are planning to alter their play areas, they have higher obligations to make the play areas accessible. Under the ADA, an "alteration" is a change that affects or could affect the usability of even a part of the facility. Examples of alterations are remodeling, renovation, rehabilitation, reconstruction, and changes in or rearrangement of structural parts or elements of the play area. When an alteration to an outdoor play area is planned, the altered area must be made accessible to children with disabilities to the "*maximum extent feasible*." This means that a child care center must make outdoor play area components accessible unless it is *virtually impossible* to do so.

If a center is altering components of the play area, child care centers must also make the ground surface surrounding the play components accessible, unless the cost of doing so would exceed 20% of the cost of *altering the play equipment*. In

addition, child care centers must make the "path of travel" to those components accessible, unless doing so would cost more than 20% of the cost of the *overall alterations*.

If you are planning to move play components within an existing area but plan no changes to the play components or the ground surface, you do not have to make the play components accessible if doing so would not be *readily achievable*. However, if you plan to make changes to the ground surface and/or the play components while moving them, you must make the play components accessible to the *maximum extent feasible*.

If a center is building a new outdoor play area, all new construction in center-based child care facilities must be made *fully accessible* to individuals with disabilities. The only exception is when it is *structurally impracticable* or physically impossible to do so. In addition to requiring all play components to be fully accessible, this provision requires both the ground surface of the play area and the paths of travel within it to be accessible.

Play components are divided into three categories: ground level, elevated, and soft contained play components. With varying degrees of difficulty, all three types can be made accessible.

- **Ground level play components** are those in which the play activity begins and ends at ground level, such as stand-alone swings, seesaws, and climbers. Also included are play items such as sand and water tables. Most ground level play components can be made accessible to children with disabilities by providing accessible ground surfaces and changes in height from the ground and spacing between items. Others may require more extensive structural changes or creativity to make them accessible.

- **Elevated play components** are those that are approached either above or below ground and are part of a composite play structure in which two or more individual items are combined into a single play activity. To be made accessible, elevated play components will usually require an accessible path of travel, along with ramps, transfer systems, or wheelchair lifts so they can be accessed by children with disabilities. A transfer system generally consists of a platform and a series of transfer steps onto which children using wheelchairs can transfer themselves in the absence of a ramp.

- **Soft contained play structures** are made of soft materials, such as plastic, netting, and fabric, and usually involve an activity within the structure, such as ball pools, climbing nets, and crawl tubes. Entry to these structures can usually be provided via an accessible path of travel, combined with access by ramp, transfer system, or platform lift.

The ADA does not require an exact number of total play components. The average child care center has four ground level play components and four elevated play components. Under the ADA, at least one of each type of each ground level component must be located on an accessible route and comply with the height, spacing, transfer support, and other related requirements set out in ADAAG 15.6.6. Elevated play components do not have to be provided, but if

they are, at least half of them must be located on an accessible route. However, when there are fewer than 20 components, they may be connected by transfer system instead of by accessible routes. When a play area contains both elevated and ground level components, the number of ground level components must be proportional to the number of elevated components.[22]

Some centers have play areas that are separated into different parts depending on the age of the child. ADAAG 15.6 applies to play areas designed for children older than two. Thus, play areas for use by younger children must be made accessible if doing so would be *readily achievable*. All other play areas must comply with ADAAG 15.6 as explained. When a single facility has multiple play areas for children of different ages, each play area is treated separately and must comply with the accessibility requirements on its own.

Some financial assistance is available to make playgrounds accessible. All small businesses are entitled to a tax credit for expenses incurred to remove architectural barriers in their facilities. Funds may also be available on a state by state basis through the Community Development Block Grant Program, the quality portion of the Child Care and Development Block Grant (CCDF or CCDBG), or a local public or private funding source. Child care providers should consult their resource and referral agencies or local child care planning councils for more information about what financial assistance may be available for architectural barrier removal.[23]

Remember, where state laws provide for substantially equivalent or greater access to and usability of the facility, departures from the ADAAG are permitted. In other words, if a state law is different from the ADAAG but it provides for better access or use of the play area by a child with a disability then the state laws should be followed.

WHAT TAX BENEFITS ARE AVAILABLE?

Two specific tax provisions were enacted to help defray costs of removing accessibility barriers. Because they are tax provisions, they will not help nonprofit organizations, but for-profit providers should take advantage of them.

The first provision, Internal Revenue Code Section 190, allows taxpayers to deduct the cost of "qualified architectural and transportation barrier removal expenses." The taxpayer may either own or lease the facility or vehicle to qualify, and the deduction is capped at $15,000. For more information, see Chapter 11 in IRS Publication 535, *Business Expenses*.

The second provision, Section 44 of the Internal Revenue Code, allows small businesses to take a tax credit for expenses connected with efforts to comply with the ADA. Expenses covered include not only removal of architectural and transportation barriers, but also provision of interpreters, readers, taped texts, modifications of equipment and devices, or other similar

expenditures. The allowable credit is 50% of any amount between $250 and $10,250 paid for a given expenditure covered by this credit. To be eligible as a small business, the program must either have had gross receipts in the preceding year that did not exceed $1 million or must employ 30 or fewer full-time employees (30 hours a week for 20 or more weeks). Any expenses incurred by a small business that exceed $20,250 may be applied toward the Section 190 deduction described above. In addition, all businesses, regardless of size, are eligible for a maximum tax deduction of $15,000 per year for the removal of architectural barriers. For more information on the credit, see Chapter 32 in the IRS Publication 334, *Tax Guide for Small Businesses*.

For additional information on these and other tax incentives, order Publication 907: *Tax Highlights for Persons with Disabilities* from the Internal Revenue Service, available for downloading on the IRS website.[24] Your local Center for Independent Living or other disability advocacy organization may have additional information about other government assistance and/or tax benefits available.

MUST I MAKE CHANGES TO MY PROGRAM'S CAR OR VAN?

If you transport the children you care for in your car or other vehicle, the rules that apply to removing architectural barriers also apply to your vehicle. If you can remove barriers in your vehicle without much difficulty or expense, then you must do so, whether you drive the children to or from child care, on field trips, or to the park. No matter where, why, or how often you drive them, if transporting the children is part of the service or program you provide, under the ADA you must transport the children with disabilities also.

While many children with disabilities will not need any special accommodations in your vehicle, some might. Certainly a child using a wheelchair will need some assistance. If making changes to your vehicle to accommodate the child is readily achievable, like moving the seats of a van to allow for more space or retrofitting a shuttlebus with a hydraulic lift, then you must make the changes. Again, these sorts of changes will likely not be readily achievable for many smaller providers, but they may be feasible for larger ones. If permanent vehicle changes are not readily achievable, you must look for and provide reasonable alternatives that *are* readily available. For a child who uses a wheelchair, this may be as simple as assisting the child into and out of the car and storing the wheelchair in the trunk.

For many child care providers, the assessment of whether a permanent vehicle change is readily achievable will be based simply on what is reasonable under the circumstances. For some larger providers, however, particularly for before and after school programs and summer programs, installing hydraulic

or other lifts is mandatory. Generally speaking, private child care providers who transport children on a fixed route[25] in vehicles that can seat more than 16 people must, without exception, use an accessible vehicle that includes permanent equipment, such as a hydraulic lift. Most other providers must alter their vehicle only if doing so is readily achievable. This **readily achievable** standard applies to all providers who transport children on an as needed (by request) basis in a vehicle that can seat more than 16 or who use a smaller vehicle. If permanent changes are not readily achievable, a provider must still assist a child with disabilities wherever it is reasonable to do so, so that child has equal access to the transportation.

MUST I PROVIDE ANY SPECIAL EQUIPMENT IN ORDER TO ENSURE EFFECTIVE COMMUNICATION FOR A CHILD WHO HAS A DISABILITY?

The ADA uses the term **"auxiliary aids and services"** to describe special equipment or services that are necessary to enhance communication for a child with a disability that affects hearing, vision, or speech and to ensure that the child is not excluded, segregated, or otherwise treated differently from other children. Auxiliary aids and services help to ensure that communication with individuals with disabilities is as effective as communication with individuals without disabilities. As with other types of accommodations, the ADA requires you to provide auxiliary aids and services for children in your program who have communication impairments, unless the particular aid or service imposes an **undue burden** or unless you can demonstrate that the requirement would **fundamentally alter the nature of your program or facility** (see Appendix A). Undue burden means that the requirement would result in a significant difficulty or expense.[26]

The types of auxiliary aids and services you may need to consider supplying to enhance communication that will enable a child with a disability to participate in your program in an integrated fashion vary as much as individual children and their needs vary. For a child with a hearing impairment, you may need to provide an interpreter, phones that are compatible with hearing aids, or a closed caption decoder, depending on the child's age and needs, the types of activities your program offers, and the size of your staff and budget. While some child care centers may be required to purchase some of the more expensive or high tech equipment, such purchases would impose an undue burden on many smaller providers. And, depending on the types of activities, much of the high tech equipment may simply be unnecessary to integrate the child into your program.

Even family child care providers with small budgets may be able to obtain special equipment to enhance communication with a child with a communication impairment more readily than you might think. Some equipment is less expensive than commonly assumed, or it may be available on loan. When faced with the decision whether to purchase special equipment for a child, it is always a good idea to investigate cost and availability before you dismiss your obligation out of hand. Many local chapters of nonprofit organizations, societies, or foundations created to support people with specific medical conditions or disabilities, such as hearing or visual impairments, may have equipment available at a reduced cost or for loan (for a partial listing of community resources to check, see pages 46-48).

If you need specialized communication equipment to integrate a child into your program, but obtaining the equipment imposes an undue burden, you must provide an alternative auxiliary aid or service, if one exists that would not impose an **undue burden or fundamentally alter the nature of your program**. For example, if a family child care provider is unable to obtain large print reading materials for a visually impaired child, and reading or spelling is part of the program, providing a magnifying glass or prism for that student may be a reasonable alternative aid.

As with other types of accommodations for children with disabilities, a provider may not pass along to the child's parents the cost of the auxiliary aids or services. You will, of course, need to take this rule into account when assessing whether accommodating the child's needs will be an undue burden and whether any reasonable alternatives exist in order to accommodate the child. For more detailed guidelines on how to treat the costs of auxiliary aids, services, or other accommodations, see sections titled *What Is a "Reasonable Accommodation"?*; *May I Charge the Family More for Serving a Child Who Has a Disability?*, and *What Tax Benefits are Available?* on pages 8, 15, and 36 respectively.

WHAT IF I RENT MY HOME OR CHILD CARE FACILITY?

If you rent your home or child care facility, it may be unclear who is responsible for making the specific changes the ADA requires to accommodate a child under your care. The ADA holds both you and your landlord responsible for complying with the law, but it does not specify who is responsible for what types of accommodations. Instead, the ADA recommends that each landlord and each tenant enter into a contract or lease specifying which party will assume which responsibilities.

The general rule for division of responsibility between a landlord and a tenant *suggested* by the ADA is:

- **The landlord** should be responsible for readily achievable removal of architectural barriers and for providing reasonable auxiliary aids in any **common areas** of a multiple unit structure such as an apartment or commercial building.
- **The tenant** would then be responsible for providing reasonable auxiliary aids, and possibly for removal of architectural barriers (if readily achievable and with permission from the landlord) in the **rental unit** being used for child care.

Before drawing up a new contract or lease with your landlord you should check your local landlord/tenant laws and your existing lease for provisions that assign the responsibility for structural improvements or modifications in a residential or commercial property to either party. Local ordinances or an existing lease may also specify the obligation of the landlord or tenant to comply with local, state, or federal laws.

Some leases may spell out who is responsible for which structural changes, but many do not. The ADA suggests that the landlord is ultimately responsible only for making architectural changes to the common areas of a multiple-unit building, and not to the rental units. This means that, unless a local law requires the landlord to change your residence or program area to bring it into compliance with the ADA, the financial burden may rest with you. Keep in mind, of course, that the ADA expects you to make only readily achievable architectural changes and that tax incentives are available to help you defray the costs (see the section titled, *What Tax Benefits Are Available?* on page 36).

Even if the responsibility of *paying* for permanent improvements to the property is yours, you will have to obtain your landlord's *permission*, preferably in writing, before you begin to make permanent changes to the property. Generally speaking, the landlord has final legal authority to decide whether to make permanent structural changes, and, if so, what changes to make. Unless your lease grants you blanket permission to make structural changes and modifications at your own discretion, you should proceed only after you have discussed them with your landlord, received her or his approval, and put the agreement in writing.

Of course, most landlords will not object to improvements that will enhance their property value. While the landlord may be under no legal obligation to assume the expense, she or he will surely benefit from any permanent improvements you make. Appealing to the landlord's sense of fairness may help you reach an agreement to share or for the landlord to fully assume the financial burden of some or all of the improvements.

Whatever you work out, be sure to have the new terms drawn up into a written contract or addendum to your lease. If you are negotiating a new lease, the terms spelling out responsibility for compliance with the ADA should be contained within a provision of the lease. Putting your agreement in writing will help you avoid renegotiation of terms you thought were already settled and save you from covering bills you thought the landlord would pick up. A written agreement will also serve to clarify to you and to others where your

responsibility begins and ends when new situations arise that require removal of architectural barriers.

WHAT IF I RENT SPACE FROM A CHURCH?

Religious organizations and entities that operate their own child care programs, and those that rent space to secular/private child care programs, are exempt from the ADA. However, it is important to check your state anti-discrimination laws as well, since state law may not exempt religious organizations. In California, for example, public accommodations operated by religious organizations of any size are required to remove barriers in order to make their facility accessible (although California's civil rights law does not require construction or renovations to accommodate people with disabilities, the California building codes do create some obligations to make religious facilities accessible except where removing barriers in an existing facility would create an unreasonable hardship).[27] In states with laws similar to California's, church-operated child care programs may face requirements very similar to those governing secular programs. In some states, religious organizations that are landlords to secular child care programs may be treated the same as any other landlord in terms of shared responsibility for accommodating people with disabilities. Laws vary from state to state.

Regardless of state law, a secular/private child care program located in a place of worship still has a legal obligation to comply with ADA requirements. Unlike with any other landlord-tenant relationship, when a church acts as a landlord to a secular child care program the legal responsibility for compliance rests solely with the tenant, even if accommodation requires some structural changes to the building. Needless to say, this will create some delicate situations for programs housed in but not operated by churches.

Because most rental situations contemplated by the ADA involve parties who both have obligations to comply with the law, the ADA left it up to individual landlords and tenants to work out their respective obligations under the lease or contract. By contrast, in states where churches are exempt, church-based, secular programs will have to negotiate leases with the understanding that they, as tenants, are solely responsible for compliance with the ADA. This relationship could become rather tricky if, for example, compliance required a program to remove barriers from the entrance of the church building all the way along a path to the room where care is provided, or if compliance required installation of a ramp at the front door of the church — areas that are not under the program's control.

In some cases, church-based, secular child care programs may be able to appeal to the church's sense of fairness, since the church surely will benefit from structural improvements to make the building more accessible to its members. Because of the mutual benefit, some churches will voluntarily

undertake the renovations, and pay for them either partially or fully, even though the church is exempt from compliance. But if the church is unable or unwilling to share the financial obligation, the child care program would have to be prepared to pay for full compliance alone unless removal of barriers would not be readily achievable to the child care program.

Of course, before any renovations can begin, you will have to secure permission from the church to undertake them. In states where a church is exempt from ADA-like requirements, it may refuse to give permission for any renovations, and it may be under no legal obligation to cooperate with your need to comply. Under California's civil rights law, churches that are landlords have no legal duty to make changes to the facility and only a limited duty to make facilities accessible under California building codes. However, churches and other landlords arguably cannot refuse to give the tenant permission to make reasonable changes that are necessary to make the facilities accessible and usable by children or staff with disabilities. Most churches are unlikely to withhold permission for reasonable alterations, but if the church chooses not to cooperate, you may be forced to relocate in order to meet your ADA obligations. Whenever permission is refused, the child care program should follow up with a letter confirming that permission for renovations that would remove barriers for a child with disabilities has been refused, and a copy of the letter should remain on file.

OTHER CONSIDERATIONS

CAN I LOSE MY LIABILITY INSURANCE IF I CARE FOR A CHILD WHO HAS A DISABILITY?

Many child care providers are concerned that their liability insurance rates will increase or their insurance will be canceled if they accept a child with disabilities. Unfortunately, ADA regulations do not address this concern adequately. In fact, the only reference to this problem is that a "public accommodation shall not refuse to serve an individual with a disability because its insurance company conditions coverage or rates on the absence of individuals with disabilities."

The intent of this section of the ADA was to address a frequently offered reason for denial of services by public accommodations. Clearly, in the past,

this has been a legitimate concern for many child care providers in deciding whether to accept children with disabilities. Now that child care programs must admit children with disabilities, the regulations fall short. While they prohibit providers from refusing care based on insurance concerns, the regulations do not take the next step and prohibit *insurers* from canceling or refusing to renew policies because a program cares for a child with a disability and is required by law to do so

If a child care program's liability insurer raises rates or discontinues a policy because the program admits a child with disabilities, the ADA may offer a remedy, but this is not yet certain. Although the regulations guarantee that an insurer will not be prohibited from underwriting or classifying "risks" or administering "risks" that are based on or not inconsistent with state law, it is a violation of the ADA for an insurer to use this rule as a subterfuge to evade the purposes of the ADA. Proving that an insurer is attempting to avoid insuring programs that care for children with disabilities, and not just exercising sound actuarial principles or acting on actual or reasonably anticipated experience, may be a very difficult case to make. A pattern of repeatedly canceling policies or raising rates to exceedingly high levels may be sufficient proof, however, particularly if the insurance company's actions do not seem to correlate with the extent of the disability in question. If such a situation arises, the child care provider may be able to sue the insurance company under the ADA. The provider in these cases should have the right to sue as *an entity or person associated with a person with a disability*, which is one of the protected classes under the ADA.

Some state laws prohibiting unfair business practices may also offer an avenue for redressing insurance issues. In California, the Unruh Civil Rights Act prohibits businesses and public accommodations from discriminating against people with disabilities, and the right to sue under this law, like under the ADA, belongs to a person who has a disability or one who is *associated* with a person who has a disability.[28] Alternatively, almost anyone may sue a business for unfair business practices under California law. The California Business and Professions Code Section 17200 probably allows a provider who cares for children with disabilities to sue an insurance company if the provider believes that the insurance company violated the Unruh Act by canceling the provider's liability insurance. Unfortunately, both types of lawsuits are, as yet, untested, and the likelihood of success cannot be accurately predicted.

ARE THERE ANY OTHER CONSIDERATIONS I SHOULD KNOW ABOUT?

Because children with special needs may be absent more often, whether due to increased susceptibility to infection or the need to see specialists, it is

important to spell out your payment requirements for absences in advance. As with any child, you should keep information on the child's health status; any special needs, including information on medication and/or other specialized procedures, and the name and telephone number of the child's physician. Apply all policies and recordkeeping requirements uniformly to all children.

For many child care programs, frequent absences without payment for any reason may become an unreasonable financial burden. You may not deny a child admission into your program based on your expectation that the child may be absent frequently due to a disability. You may, however, have a uniform policy that requires payment for days any child misses, regardless of the reason for the absence. Once admitted, then, nonpayment for any reason, including absence, can be grounds for termination, even if the absences are due to special needs associated with the child's disability, the parent's unreliability, domestic problems in the child's home, or any number of other reasons. However, if the absences are due to a child's disability, you will be expected to exercise reasonable flexibility with the policy prior to discontinuing care. If the child's absences are paid, you should not discontinue care based on excessive absences.

DOES SPECIAL EDUCATION OFFER ANY CHILD CARE ASSISTANCE FOR CHILDREN WITH SPECIAL NEEDS?

The "**Individuals with Disabilities Education Act (IDEA)**,"[29] is another significant federal law affecting children with disabilities. It requires that children from birth through age 21 who have disabilities and, in some states, infants and toddlers "at risk of substantial developmental delay" receive early intervention or special education and related services from the state. All 50 states have state plans and have come into compliance with Special Education (Part B) requirements for preschool (3-5 years old) and school age (5-21 years old) children, as well as Early Intervention (Part C) for children from birth to age 3. The IDEA defines "disability" differently than the ADA, and not all children whom the ADA protects qualify for services under the IDEA. (See endnotes 30 and 31 for a detailed description of conditions the IDEA covers.)

All states have developed programs to provide services required under the IDEA to serve children from birth through age 21. Under these programs, children three years and older who have disabilities as defined by the IDEA are entitled to a broad range of support services at no cost to their families. Early Intervention services for children under three may be provided for free or based on a sliding fee scale. For parents in need of full-day programs, it is important to note that the IDEA law supports special education and related

services but not programs and therefore, all-day services may not be available through the IDEA for children under the age of three.

Qualifying children are entitled to a free assessment of their needs and disabilities as well as the development of a personalized plan of supportive services to meet their special education needs. In California, these services can include speech and language therapy, audiological services, occupational therapy, physical therapy, psychological services, family training, special education or instruction, child care, transportation, behavior modification, and many others. In California, services are available for children under three who are experiencing or are *at risk* of developmental delays.[30] Older children qualify if they meet a more specific definition of disability.[31] Other states make similar services available, but the services may vary as to whether they serve *at risk* children under three. Each state establishes its own definition of developmental delays. A complete list of state definitions can be found at http://www.nectac.org.

Providers who are caring for a qualifying child with a disability in California should advise the parents to contact their school district's Department of Special Education (listed in the phone book). In California, one can also contact the local Regional Center (these can be found either in the phone book under the Department of Developmental Services or online at http://www.dds.cahwnet.gov). Outside California, the names of the agencies may vary somewhat, but your school district special education department, your local child care resource and referral agency, or a local disability agency should be able to direct you appropriately. You can direct legal questions to the state Protection and Advocacy organization, which provides legal services to people with disabilities (see National Association of Protection and Advocacy, Inc., listed in the *Legal and Government Resources* section on page 48).

You should encourage parents of children with disabilities to look into the availability of evaluations for their child as early as possible. Parents should make a written request to the school district and the Regional Center to assess whether their child is entitled to supportive services and, if so, what services, and to create for the child a special program that includes those supportive services. Let the parents know that child care may be one of the available services if such care is necessary to fulfill the plan's goals. Child care must be specifically requested; the plan will not include it automatically. Children from birth to age three are entitled to have care offered in their natural environments and in the least restrictive environment for children from three to 21. Depending on the child's individual needs, this could include either public or private child care programs as well as preschool programs, as these may be natural environments for children in the same age range. In other words, IDEA services can be delivered in a child care setting. Part C of the IDEA (covering children from birth to three) specifically mentions the preschool setting.

Children placed in preschools under the IDEA are entitled to receive preschool services in an integrated setting, if appropriate. The need for integrated services should be documented in a child's individualized plan. While some school districts may tend to direct qualifying children with

individualized plans exclusively to segregated preschool programs for children with disabilities, this will often be inappropriate for the child. A growing number of in home services and inclusive child care programs are available and parents have the right to request an integrated child care placement.

It is important to note that at the time of this writing, the above information on IDEA was correct. However, be aware that in 2003 IDEA will be reauthorized at the federal level and therefore changes in the law may occur. Consequently, check for up to date information on IDEA before relying on the information in this section.

ARE THERE BOOKS AND RESOURCES TO HELP ME LEARN MORE ABOUT CHILDREN WITH SPECIAL NEEDS?

Yes. The following list of books and community and governmental resources, while not exhaustive, will offer some assistance. Remember, you can often find other resources in your community by calling your local resource and referral agency.

Helpful Materials

- Also from the Child Care Law Center ADA Series: Available in English, Chinese and Spanish: *Child Care and the ADA: Highlights for Parents of typically developing children* (detailed booklet); *Child Care and the ADA: Highlights for Parents of Children with Disabilities* (detailed booklet).
- Project Head Start Series — Order from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402; website: http://www.gpo.gov. Some titles include: *ABC's of Safe and Healthy Child Care: A Handbook for Child Care Providers*, 1998; *Including Children With Significant Disabilities in Head Start*, 1998; *Preventing and Managing Communicable Diseases*, 1996; *Supporting Children With Challenging Behaviors: Relationships Are Key*, 1997; *Translating the Individualized Education Program (IEP) Into Everyday Practice*, 1998.
- Finnie, Nancie, *Handling the Young Cerebral Palsied Child at Home.* E.P. Dutton, New York, 1991.
- Exceptional Parent Magazine P.O. Box 2078 Marion, OH 43306, 877-372-7368 Magazine about parenting children with special needs.
- Featherstone, Helen, *A Difference in the Family: Living with a Disabled Child.* Penguin Books, New York, 1981.

- Froschl, Colon, Rubin and Sprung, *Including All of Us: An Early Childhood Curriculum About Disability*. Educational Equity Concepts, 1984.
- Gould, Patti and Sullivan, Joyce, *The Inclusive Early Childhood Classroom*. Gryphon House, 1999. http://www.ghbooks.com/showbook.cfm?code=19652.
- Guralnick, Michael J., Ph.D. (Ed.), *Early Childhood Inclusion Focus on Change*. Paul H. Brooks Publishing Company, Inc., 2001. http://www.pbrookes.com/store/books/obrien-2967/index.htm.
- O'Brien, Marion, Ph.D. , *Inclusive Child Care for Infants and Toddlers: Meeting Individual and Special Needs*. Paul H. Brooks Publishing Co., Inc., 1997, http://www.pbrookes.com/store/books/obrien-2967/index.htm.
- Siegfried M. Pueschel, et al, *The Special Child : A Source Book for Parents of Children with Developmental Disabilities*, Second Edition, Brookes Publishing, Customer Service Dep't, P.O. Box 10624, Baltimore, MD 21285, 800-638-3775, fax 410-337-8539, http://www.brookespublishing.com/index.htm.
- Saifer, Steffen, *Practical Solutions to Practically Every Problem: The Early Childhood Teacher's Manual*. Redleaf Press. St. Paul, MN, 1990.
- Bricker, Diane D. & J. Cripe, *An Activity-Based Approach to Early Intervention*. Paul T. Brookes Publishing Co., Baltimore, MD, 1998.
- Capper Foundation, The Early Intervention Team, *PROJECT KIDLINK: Bringing Together Disabled and Non-Disabled Preschoolers*. Communication Skill Builders, Tucson, AZ, 1990.
- Hinds, Diane & Kim Holland, *The Infant with Special Needs: An Introductory Curriculum for Service Providers*. CDC/Infant Care Center Director, Citrus Community College District, 1000 West Foothill Boulevard Glendora, CA 91741, 626-914-8501, e-mail dhinds@citrus.cc.ca.us, http://info.citruscollege.com/.
- Kuschner, Anne, *Desired Results: Access for Children with Disabilities Project*, a project of the California Institute on Human Services, Sonoma State University, 1801 East Cotati Ave., Rohnert Park, CA 94928, 707-664-2418, http:// www.sonoma. edu/cihs/standards.html. Replicable statewide training model for CA to promote appropriate, integrated child care to young children with disabilities.
- MN Department of Children, Families and Learning, *A Manual for Family Child Care Professionals*. http://www.minnesotabookstore.com.
- MN Department of Children, Families and Learning, *A Manual for Child Care Center Professionals*. http://www.minnesotabookstore.com.
- Rogers, Cosby S. & Janet K. Sawyers, *Play In the Lives of Children*. NAEYC, Washington, D.C., 1988.
- *BANANAS' Child Care Provider's Guide to Identifying and Caring for Children with Special Needs*. Available from BANANAS, Inc., 5232 Claremont Ave., Oakland, CA 94618, 510-658-1409.

- Special Needs Project — a mail order service for books on special needs, 324 State St., Suite H, Santa Barbara CA93101, 800-333-6867.
- The Arc (A National Organization on Mental Retardation), P.O. Box 1047, Arlington, TX 76004, 817-261-6003, http://thearc.org/welcome.html The Arc's book, *All Kids Count: Child Care and the Americans with Disabilities Act (ADA)*, is a guide to inform the child care industry about the ADA and to help child care providers realize the importance and value of including all children in regular child care settings. This publication outlines accommodations that can facilitate including children with a wide range of disabilities in early childhood programs. The Arc's Website contains many full-text documents on working with children with disabilities, information on specific disabilities, and information in both Spanish and English on the ADA as it relates to child care.
- Chandler, Phyllis, A., *A Place For Me: Including Children with Special Needs in Early Care and Education Settings.* Family Service of Omaha. Omaha, NE, 1994. Order from: NAEYC, 1509 16th St., NW, Washington, DC, 20036, 202-232-8777 or 800-424-2460.
- Kids Included Together - San Diego, Inc., *Together We Are Better* - a training manual for providers, (1999), *Together We Are Better*, a training video (1999). Order from: Kids Included Together - San Diego, Inc., 3377 Carmel Mountain Rd., 2nd Floor, San Diego, CA 92121.
- The Texas Council for Developmental Disabilities, *The ABCs of Inclusive Child Care*, order for free online at http://www.txddc.state.tx.us/menus/fset_pub_matrl.asp or contact: 6201 E. Oltorf, Suite 600, Austin, TX 78741, 512-437-5432, 512-437-5431 TDD, 800-262-0334 in Texas, 512-437-5434 fax.

Websites:

- National Information Center for Children and Youth with Disabilities: http://www.nichcy.org
- Circle of Inclusion: http://www.circleofinclusion.org

Legal and Governmental Resources

- *The Americans with Disabilities Act Handbook*, Equal Employment Opportunity Commission and the U.S. Department of Justice, October, 1992. To obtain a copy, contact your local U.S. Government Printing Office, or request one through the U.S. Government Printing Office, Superintendent of Documents, Mail Stop: SSOP, Washington, DC 20402. U.S. Government Printing Office website: http://bookstore.gpo.gov.
- U.S. Department of Justice the Americans with Disabilities Act Information and Assistance Hotline (between 9:30 a.m. and 5:30 p.m.

EST weekdays, except Thursdays: 12:30-5:30 p.m. EST) at (800) 514-0301 or (800) 514-0383 (TDD); website: http://www.usdoj.gov/crt/ada.

- California Department of Education, CDE Press, Sales Unit, P.O. Box 271, Sacramento, CA 95812b 800-995-4099; http://www.cde.ca.gov/cdepress. Some titles: *Just Kids: A Practical Guide for Working with Children Prenatally Substance-Exposed, Just Kids Video; Just Kids Guide; Just Kids Manual; Project EXCEPTIONAL: A Guide for Training and Recruiting Child Care Providers to Serve Young Children with Disabilities; Every Little Bite Counts: Supporting Young Children with Special Needs at Mealtime.*
- Equal Opportunity Employment Commission (EEOC), 1801 L Street, NW, Washington, DC 20507, 800-669-4000 (voice), 800-877-8339 (TDD)
- Department of Transportation, 400 Seventh Street, SW, Washington, DC 20590, (202) 366-9305 (voice) (202) 755-7687 (TDD)
- The Access Board, 1331 F Street, NW, Suite 1000, Washington, DC 20004, 202-272-5434 (v), 202-272-5449 (TTY), 202-272-5447 (fax), 800-872-2253 (v), 800-993-2822 (TTY), email: info@ access-board.gov, email directory; website: http://www.access-board.gov/.
- Federal Communications Commission, 445 12th St. SW, Washington, DC 20554, 888-225-5322 (voice toll-free), 888-835-5322 (TTY) toll-free, website: http://www.fcc.gov.
- Internal Revenue Service (tax credits and deduction information), http://www.irs.ustreas.gov/index.html.
- Child Care Law Center, 221 Pine St., Third Floor, San Francisco, CA 94104. Calls for information and requests for service on Monday, Tuesday and Thursday, 12:00 noon to 3:00 p.m. PST, 415-394-7144.
- Disability Rights Education & Defense Fund, Inc. (DREDF) 2212 Sixth St., Berkeley, CA 94710, Voice and TTY 510-644-2555, fax 510-841-8645.
- Bazelon Center for Mental Health Law, 1101 15th Street, NW, Suite 1212, Washington, DC 20005, fax 202-223-0409, website; http://www.bazelon.org/children.html. They have advocacy resources on the ADA and SSI and children with disabilities.
- National Information Center for Children and Youth with Disabilities, (NICHCY), P.O. Box 1492, Washington, DC 20013, 800-695-0285 Voice and toll-free, 202-884-8441 fax, 202-884-8200 Voice - TDD, http://www.healthfinder.gov/orgs/HR2002.htm.
- National Association of Protection and Advocacy, Inc., 900 Second St., NE, Suite 211, Washington, DC 20002, 202-408-9514, fax 202-408-9520, http://www.protectionandadvocacy.com/. Call this number to obtain the phone number of the Protection and Advocacy office in your state capitol.
- Regional Disability & Business Technical Assistance Centers disseminate information, provide technical assistance, develop resources

for businesses, disability organizations, state and local governments, educational programs, news media, labor organizations, public and private organizations regarding the ADA, 800-949-4232 (Voice & TDD); http://www.pacdbtac.org.

Non-Legal and Non-Governmental Resources

- American Cancer Society, 90 Park Avenue, New York, NY 10016, 212-599-8200; 800-ACS-2345; http://www.cancer.org.
- American Diabetes Association, Attn: Customer Service, 1701 N. Beauregard St., Alexandria, VA 22311, 1-800-DIABETES (342-2383); http://www.diabetes.org.
- American Foundation for the Blind, 11 Penn Plaza, Ste. 300, New York, NY 10001; 800-AFB-LINE (232-5463); 212-502-7600; http://www.afb.org.
- American Heart Association, 7272 Greenville Ave., Dallas, TX 75231, 800-242-8721; http://www.americanheart.org.
- American Lung Association, 1740 Broadway, New York, NY 10019, 212-315-8700; http://www.lungusa.org.
- American Speech-Language-Hearing Association, 10801 Rockville Pike, Rockville, MD 20852, Voice or TTY: 800-638-8255; http://www.asha.org.
- The ARC, Publications Desk, 3300-C Pleasant Valley Lane, Arlington, TX 76015, 817-640-0204; http://www.thearc.org.
- The Action Starts Here (TASH), 29 W. Susquehanna Ave., Ste. 210, Baltimore, MD 21204, 410-828-8274; http://www.tash.org.
- The Council for Exceptional Children (CEC), 1110 North Glebe Rd., Ste. 300, Arlington, VA 22201, 703-620-3660; TTY 703-264-9446; www.cec.sped.org.
- Cystic Fibrosis Foundation, 6931 Arlington Rd., Bethesda, MD 20814, 800-344-4823; http://www.cff.org.
- National Down Syndrome Society, 666 Broadway, New York, NY 10012, 800-221-4602; http://www.ndss.org/mail.html.
- Easter Seals Society, 230 W. Monroe St., Suite 1800, Chicago, IL, 60606, Voice 312-726-6200, TTY 312-726-4258, Toll-free 800-221-6827; http://www.easter-seals.org.
- Epilepsy Foundation of America, 4351 Garden City Drive, Landover, MD 20785, 30l-459-3700 or 800-332-1000; http://www.efa.org.
- Federation for Children with Special Needs, 1135 Tremont St., Ste. 420, Boston, MA 02120, 617-236-7210 or (800) 331-0688 (in MA); http://www.fcsn.org.

- American Sickle Cell Anemia Association Support Groups; 216-229-8600; http://www.ascaa.org/support.asp.
- Spina Bifida Association of America, 4590 MacArthur Blvd., NW, Ste. 250, Washington, D.C. 20007, Voice 800-621-3141 or 202-944-3285; http://www.sbaa.org.

Endnotes

[1] Unruh Civil Rights Act, California Civil Code Section 51 and Government Code Section 12926.

[2] Americans with Disabilities Act: An Implementation Guide. M. Golden, L. Kilb, and A Mayerson. The Disability Rights and Education and Defense Fund 1993.

[3] In most cases, if you take steps to comply with ADA requirements, you will also be in compliance with Section 504 of the Rehabilitation Act.

[4] *Public Accommodations* under the ADA covers a wide variety of private businesses that are open to the public, including (but not limited to) hotels, restaurants, retail stores, amusement parks, recreational programs, and child care programs.

[5] Department of Justice website: http://www.usdoj.gov/crt/ada/adahom1.htm.

[6] See the section titled *What Tax Benefits Are Available?* on page 36 for a more detailed description of the tax benefits available to your program and the section titled *May I Charge the Family More for Serving a Child Who Has a Disability?* on page 15 for a more in-depth discussion on how to treat the costs associated with accommodating the needs of a child with a disability.

[7] Grist v. State Bd. For Technical & Comprehensive Educ., No.94-790--19 (D.S.C. 1994).

[8] The NIH strongly urges you to call rather than write if at all possible. They say you are much more likely to get a prompt answer, or any answer at all, if you contact them by phone.

[9] The ADA only permits *requiring* health tests or procedures when the child poses a direct threat to the health and safety of others. For all practical purposes, it is highly unlikely that a child's condition will ever warrant requiring health testing, and this is particularly true for children who may be infected with HIV. While some conditions associated with HIV may pose a direct threat, the HIV status, in and of itself, does not. It is, therefore, impermissible ever to require HIV screening of children for whom you are considering caring.

[10] The laws that require the practice of universal infection control measures in child care are commonly referred to as the *OSHA regulations*. See the section titled *Who Is Required to Establish Universal Precautions?* on page 20 for details on what the OSHA regulations are and to whom they apply.

[11] The hepatitis B virus is transmitted virtually the same way as HIV, but it is more contagious. In the child care setting, the only risk of transmission of either virus is through blood, and universal precautions are designed to prevent either virus from spreading. While the overall incidence of both viruses among children is extremely low, universal precautions should always be practiced uniformly in every child care program as a means of ensuring a safe environment for everyone.

[12] The Occupational Safety and Health Administration regulations ("OSHA regulations"), 29 CFR 651 et seq., are federal regulations that apply to all employers who have any employees, substitutes, or volunteers who receive in-kind compensation unless state level OSHA regulations have been adopted. (see below) The federal OSHA regulations that address bloodborne

pathogens can be found at 29 CFR 1910.1030. Employer compliance with these regulations or the equivalent state OSHA regulations is mandatory for the safety of each employee or volunteer who is reasonably anticipated to come into contact with blood during the course of performing her or his job. This rule is very broad and is likely to apply to most child care providers.

Some (but not all) states have state level OSHA offices. Those that do probably issued regulations that are parallel to the federal regulations described in this publication. In those states, the state regulations apply. Most of these state regulations are very similar to the federal regulations, but some may go beyond the federal requirements. Check with your state's Department of Labor to find out if your state has an OSHA office, and, if so, obtain a copy of your state's OSHA "bloodborne pathogens" regulations. See http://www.osha.gov/html/oshdir.html for a list of state and federal Regional OSHA Offices. In states without state level OSHA offices, the federal regulations described in this publication apply.

The federal OSHA regulations require the employer to adopt and implement a written uniform infection control policy in the workplace. Additional requirements apply, as well, including a hepatitis B vaccination requirement; required training for employees on universal infection control measures, transmission of HIV and HBV, etc.; and exposure reporting requirements. For a more complete description of your responsibilities under these OSHA regulations, contact your nearest state or federal Department of Labor OSHA Office (if your state has an OSHA office, contact the state, rather than the federal office).

[13] Under federal regulations, any common household soap is sufficient. Anti-bacterial soap does not provide added protection. But check your state regulations, if applicable, to determine if particular soaps or disinfectants are required in your state.

[14] Hepatitis B virus.

[15] See Appendix B for a reproduction of the biohazardous waste symbol.

[16] Sharps Disposal by Mail is a service available throughout the U.S. that will allow you to dispose of your Sharps containers by mail for a fee. Call (877) 927-8363 for more information.

[17] California law defines *non-ambulatory children* as those who use wheelchairs and any other children who are unable to leave the building unassisted during an emergency. Ironically, infants (under the age of two) are considered ambulatory under this definition.

[18] For a more detailed discussion on making your child care facility accessible, see the section titled *Must I Make Physical Changes to My Home or Child Care Facility?* on page 32.

[19] For an extensive review of state policies, see State Policies Impacting the Participation of Young Children with Medical Needs in Child Care by Dale Borman Fink. Published by University of Connecticut Center for Excellence in Developmental Disability Education, Research and Services (2002).

[20] Unlike the standard for *undue burden*, which requires you to accommodate a child with a disability in non-architectural ways unless doing so causes you a *significant amount of difficulty or expense*, you only need to remove architectural barriers if it can be done *without much difficulty or expense*. In other words, you are expected to make greater efforts to eliminate discriminatory practices and to supply needed equipment and services to children with disabilities than you are to remove architectural barriers.

[21] The ADA provides an extensive list of suggested barriers to be removed, depending on what is readily achievable for a given provider. Some of the items on the list are: installing ramps; making curb cuts in sidewalks; repositioning furniture, telephones and shelves; installing flashing alarm lights; widening doors or doorways; installing accessible door hardware; installing raised toilet seats or grab bars in the bathroom; removing high-pile, low-density carpeting.

[22] Consult ADAAG 15.6.2.2 to determine the exact number of ground level play components required when both types of components are provided.

[23] See www.usdoj.gov/crt/ada/taxpack.htm for more detailed information on ADA-related tax incentives.

[24] IRS website: http://www.irs.gov/pub/irs-pdf/p907.pdf.

[25] A *fixed route* is one that is followed on a regular schedule (for example, daily or twice a day) and for which advance requests for transportation are unnecessary (the same stops are made each trip and special detours are not offered).

[26] See the section titled *What Is a "Reasonable Accommodation"?* on page 8 for a more detailed discussion.

[27] California Building Code, Title 24, Part 2, Section 1104B.6.

[28] California Civil Code Section 51 and California Government Code Section 12926(m).

[29] The IDEA is the new name for the federal law that sets forth requirements and funding for state programs to offer assessments, services, and education for children with special needs. This law, formerly referred to as *Public Law 94-142*, requires that states provide special education for 3-21 year olds. It also contains *Part C of Public Law 105-17* or 20 U.S.C. 1401 *et seq*, which requires that states provide early intervention for children from birth to age three.

[30] *Developmental delays* generally include neurological or genetic conditions such as Down syndrome, spina bifida, and cerebral palsy. Children who are *at risk for developmental delay* may be so because of prematurity, birth complications, chronic illnesses or other reasons.

[31] Children with disabilities under the IDEA include children with "…mental retardation, a hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance…, an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who by reason thereof, needs special education and related services." 34 CFR 300.7(a)