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MSCOD

Minnesota State Council On Disability

Your Technical Assistance & Training Resource

MINNESOTA STATE COUNCIL ON DISABILITY
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MSCOD
Minnesota State Council
On Disability

TO: Members of the Minnesota Legislature
FROM: The Minnesota State Council on Disability
David Schwartzkopf, Chair
Joan Willshire, Executive Director
RE: Legislative Reference Manual on Disability Resources

Dear Member:

On behalf of the Communications Committee of the Council, we are pleased to present you with this reference manual that contains information on the Council and its resources, national and state organizations, current issues, reports and statistics pertaining to the population of people with disabilities in Minnesota.

The reference manual was formulated based on ongoing inquiries made and topics we believe are of importance to members of the Minnesota House and Senate. The reference manual is provided in a three-ring binder format so that additions can be made, for example to the section on disability-related legislative issues. When additional materials for the manual are mailed to you a green tab sheet will be included to separate sections. Timely information on current disability-related legislative issues will be copied on pink paper to alert you to their importance.

The Council is pleased to provide you with good quality disability-related information...we are your State Disability Resource.

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MSCOD
Minnesota State Council On Disability

MISSION • VALUES • VISION

The Minnesota State Council on Disability is an agency that advises, provides technical assistance, collaborates and advocates to expand opportunities, improve the quality of life and empower all persons with disabilities.

VALUES

We operate with a specific set of values:

- Inherent respect for all
- Integrity
- Independence

VISION

To be a primary, productive resource for disability-related information providing leadership and promoting innovative policies through:

- Effective administrative operations
- Legislative interaction, and
- Statewide collaboration

CUSTOMERS

Our customers are:

- People with disabilities and their families
- The Governor
- Legislature
- State and local government
- Private Agencies
- Employers
- General Public

SERVICES

Our Services include:

- Review disability issues and advise State government
- Promote coordinated, collaborative interagency efforts
- Provide information and referral
- Collect, conduct and make disability-related research and statistics available to all customers
- Advocate for policies and programs that promote the quality of life for people
- with disabilities

Minnesota Statutes 2004, Table of Chapters

Table of contents for Chapter 256

256.482 Council on Disability.

Subdivision 1. Establishment; members. There is hereby established the Council on Disability which shall consist of 21 members appointed by the governor. Members shall be appointed from the general public and from organizations which provide services for persons who have a disability. A majority of council members shall be persons with a disability or parents or guardians of persons with a disability. There shall be at least one member of the council appointed from each of the state development regions. The commissioners of the Departments of Education, Human Services, Health, and Human Rights and the directors of the Rehabilitation Services and State Services for the Blind in the Department of Employment and Economic Development or their designees shall serve as ex officio members of the council without vote. In addition, the council may appoint ex officio members from other bureaus, divisions, or sections of state departments which are directly concerned with the provision of services to persons with a disability.

Notwithstanding the provisions of section 15.059, each member of the council appointed by the governor shall serve a three-year term and until a successor is appointed and qualified. The compensation and removal of all members shall be as provided in section 15.059. The governor shall appoint a chair of the council from among the members appointed from the general public or who are persons with a disability or their parents or guardians. Vacancies shall be filled by the authority for the remainder of the unexpired term.

Subd. 2. Executive director; staff. The council may select an executive director of the council by a vote of a majority of all council members. The executive director shall be in the unclassified service of the state and shall provide administrative support for the council and provide administrative leadership to implement council mandates, policies, and objectives. The executive director shall employ and direct staff authorized according to state law and necessary to carry out council mandates, policies, activities, and objectives. The salary of the executive director and staff shall be established pursuant to chapter 43A. The executive

director and staff shall be reimbursed for the actual and necessary expenses incurred as a result of their council responsibilities.

Subd. 3. Receipt of funds. Whenever any person, firm, corporation, or the federal government offers to the council funds by the way of gift, grant, or loan, for purposes of assisting the council to carry out its powers and duties, the council may accept the offer by majority vote and upon acceptance the chair shall receive the funds subject to the terms of the offer. However, no money shall be accepted or received as a loan nor shall any indebtedness be incurred except in the manner and under the limitations otherwise provided by law.

Subd. 4. Organization; committees. The council shall organize itself in conformity with its responsibilities under sections 256.481 to 256.482 and shall establish committees which shall give detailed attention to the special needs of each category of persons who have a disability. The members of the committees shall be designated by the chair with the approval of a majority of the council. The council shall serve as liaison

in Minnesota for the president's committee on employment of the handicapped and for any other organization for which it is so designated by the governor or state legislature.

Subd. 5. Duties and powers. The council shall have the following duties and powers:

(1) to advise and otherwise aid the governor; appropriate state agencies, including but not limited to the Departments of Education, Human Services, Employment and Economic Development, and Human Rights and the Divisions of Rehabilitation Services and Services for the Blind; the state legislature; and the public on matters pertaining to public policy and the administration of programs, services, and facilities for persons who have a disability in Minnesota;

(2) to encourage and assist in the development of coordinated, interdepartmental goals and objectives and the coordination of programs, services and facilities among all state departments and private providers of service as they relate to persons with a disability;

(3) to serve as a source of information to the public

regarding all services, programs and legislation pertaining to persons with a disability;

(4) to review and make comment to the governor, state agencies, the legislature, and the public concerning adequacy of state programs, plans and budgets for services to persons with a disability and for funding under the various federal grant programs;

(5) to research, formulate and advocate plans, programs and policies which will serve the needs of persons who are disabled;

(6) to advise the Departments of Labor and Industry and Employment and Economic Development on the administration and improvement of the workers' compensation law as it relates to programs, facilities and personnel providing assistance to workers who are injured and disabled;

(7) to advise the Workers' Compensation Division of the Department of Labor and Industry and the Workers' Compensation Court of Appeals as to the necessity and extent of any alteration or remodeling of an existing residence or the building or purchase of a new or different residence which is

proposed by a licensed architect under section 176.137;

(8) to initiate or seek to intervene as a party in any administrative proceeding and judicial review thereof to protect and advance the right of all persons who are disabled to an accessible physical environment as provided in section 16B.67; and

(9) to initiate or seek to intervene as a party in any administrative or judicial proceeding which concerns programs or services provided by public or private agencies or organizations and which directly affects the legal rights of persons with a disability.

Subd. 5a. Renumbered 16B.055, subd 2

Subd. 5b. Meetings. (a) Notwithstanding section 13D.01, the Minnesota State Council on Disability may conduct a meeting of its members by telephone or other electronic means so long as the following conditions are met:

(1) all members of the council participating in the meeting, wherever their physical location, can hear one another and can hear all discussion and testimony;

(2) members of the public present at the regular meeting location of the council can hear all discussion and all votes of members of the council and participate in testimony;

(3) at least one member of the council is physically present at the regular meeting location; and

(4) all votes are conducted by roll call, so each member's vote on each issue can be identified and recorded.

(b) Each member of the council participating in a meeting by telephone or other electronic means is considered present at the meeting for purposes of determining a quorum and participating in all proceedings.

(c) If telephone or another electronic means is used to conduct a meeting, the council, to the extent practical, shall allow a person to monitor the meeting electronically from a remote location. The council may require the person making such a connection to pay for documented marginal costs that the council incurs as a result of the additional connection.

(d) If telephone or another electronic means is used to conduct a regular, special, or emergency meeting, the council

shall provide notice of the regular meeting location, of the fact that some members may participate by electronic means, and of the provisions of paragraph (c). The timing and method of providing notice is governed by section 13D.04.

Subd. 6. Repealed, 1975 c 315 s 26

Subd. 7. Collection of fees. The council is empowered to establish and collect fees for documents or technical services provided to the public. The fees shall be set at a level to reimburse the council for the actual cost incurred in providing the document or service. All fees collected shall be deposited into the state treasury and credited to the general fund.

Subd. 8. Sunset. Notwithstanding section 15.059, subdivision 5, the Council on Disability shall not sunset until June 30, 2007.

HIST: 1973 c 254 s 3; 1973 c 757 s 2; 1975 c 61 s 1; 1975 c 271 s 6; 1975 c 315 s 18; 1975 c 359 s 23; 1977 c 177 s 2; 1977 c 305 s 45; 1977 c 430 s 14; 1983 c 216 art 2 s 5; 1983 c 260 s 56; 1983 c 277 s 2; 1983 c 299 s 25; 1984 c 654 art 5 s 58; 1Sp1985 c 14 art 9 s 75; 1986 c 444; 1987 c 354 s 6; 1988 c 629

s 50; 1989 c 335 art 1 s 185,186; art 4 s 67; 1991 c 292 art 3 s
7; 1994 c 483 s 1; 1Sp1995 c 3 art 16 s 13; 1996 c 451 art 6 s
7; 1999 c 250 art 1 s 114; 2001 c 161 s 45; 1Sp2001 c 9 art 13 s
21; 2003 c 130 s 12; 1Sp2003 c 14 art 3 s 16; 2004 c 195 s 1;
2004 c 206 s 35,52

MSCOD STRATEGIC VISION STATEMENTS FOR 2004/2005

I. MSCOD will provide background research and data for use in decision making by the Governor, legislators, state agencies, disability organizations, and citizens.

- *Staff will gather valid research data, organize data and determine where to use it to develop good policy using inter-agency and outside resources.*

- *Staff will search for various grant opportunities.*

I. TACTICS-

- Conduct a housing needs Survey to the 87 counties in MN.
- Conduct Vocational Rehabilitation waiting list survey for those who are on this waiting list. Determine what services can be provided while on the waiting list.
- Use data from the Annual survey conducted by the Centers for Survey Research at the U of M and the Humphrey Institute for legislative initiatives.
- Olmstead Act-survey community on what people would like to see happen and determine format and outcome of what should occur in this area for the state.
- Hire part-time research/data analyst to gather data, organize information and write grants where appropriate.

II. MSCOD will continue to be a resource for specific disability issues.

- *Staff will maintain their expertise in general disability issues, with an emphasis on the following:* ***Accessibility, Employment, Housing, Olmstead Act and Rural Transportation,*** *while continuing to respond to individual inquiries.*

- *Staff will increase the number of advisory recommendations prepared for the Governor's office, legislature, state agencies, and other disability organizations.*

- *Staff will work with the MN Consortium for Citizens with Disabilities (MN-CCD) on issues specific such as Healthcare, Housing, Transportation and other issues as they arise.*

- *Staff will continue to use their expertise in developing and conducting trainings for the state and the public.*

II. TACTICS

- Election Equipment Bill
- Technical Assistance and coaching
- Advisory Recommendations such as: Disability Parking, Housing, Olmstead, Rural Transportation, Homeland Security and emergency evacuation, accessible voting, and others.
- Training-ongoing areas such as: access, disability awareness, ADA, Emergency Evacuation and Homeland Security and employment issues.

III. MSCOD will partner and build relationships to effectively and efficiently serve the state and disability community.

- *Staff will reexamine partnerships and clarify roles, responsibilities, and seek new partnerships to leverage resources.*
- *Staff will strengthen MSCOD presence at the legislature.*
- *Staff will increase the level of technology used within the office.*
- *Collaborating with Assistive Technology Minnesota (ATMn) will be essential to succeed in technology.*

III. TACTICS-Collaborating with:

- Public Safety and all other state agencies on emergency evacuation and Homeland Security
- DHS, other state agencies and the disability community in regard to Olmstead
- ATMn in areas of employment and assistive technology
- Other state agencies that the Council has not worked with before and other organizations to attend conferences and exhibit display booths: ADA Minnesota, ATMn, Department of Human Rights, Business Leadership Network (BLN), at conferences such as, Aging Conference, Human Rights Day, MN Social Services Association.
- All state agencies when appropriate to develop interagency contracts to create stronger bonds within government focusing their work on disability issues whenever possible
- Governor, Legislature and state agencies to develop recommendation process, so as MSCOD would become a part of budget process when governor and state agencies are reviewing budgets to strengthen disability presence within state government

Other areas:

- Council members will attend local community events with display booth
- All training presentations when possible will be conducted in Power Point style via the computer
- Renovate old training videos by using a grant from ADA Minnesota and the assistance of the area state vocational schools
- Create binder for entire legislature containing disability information that will be updated with current disability issues during the legislative session.

IV. MSCOD will continue to emphasize customer focus and quality improvement.

- *Staff will continue to respond to complaints related to alleged judicial administrative violations (per the statute.)*
- *Staff will assist with disability awareness training within agencies.*
- *Staff will seek an executive order to affirm the ADA within all state agencies in Minnesota and the elimination of the word "Handicap" in all state statutes.*

IV. TACTICS

- The Council will conduct an annual survey to determine customer satisfaction of agency.
- *Maintain Council's current participation in CORE (state management and supervisory training).*
- Council staff currently serves on the Legal Aid Board of Directors and also on an Oversight Committee for the Disability Law Center (DLC). MSCOD staff and DLC staff work cooperatively on the implementation of HAVA and related issues. MSCOD staff consult and assist on individual DLC client cases on an as needed basis
- MSCOD will continue to meet with Department of Employee relations DOER ACCESS group, which is a collaboration of state agencies focusing on ADA compliance activities for state government.
- MSCOD will work with the Governor's Council on Developmental Disabilities (DD) on the elimination of the word "Handicap" from all state statutes since the DD Council has initiated this bill.
- Staff will seek an executive order to affirm the State's commitment to the ADA.

MEMBERSHIP ROSTER
JANUARY 2004

NAME	REGION	TERM EXPIRES
Susan Abderholden 3444 - 46th Avenue South Minneapolis, MN 55406-2931 H - (612) 724-5023 O - (651) 645-2948 Health/Human Services Committee	11 E-Mail: sabderholden@nami.org	1/05
Sister Baptiste Fish 1001 14th St. NW, #100 Rochester, MN 55901 H – (507) 282-7441	10 E-Mail: bap.fish@juno.com	1/07
Sylvia Carty 737 Hague Avenue St. Paul, MN 55104 H - (651) 222-4320	11	1/07
Nancy Eustis 825 Summit Avenue, Apartment #601 Minneapolis, MN 55403-3185 H - (612) 381-0366 O - (612) 625-4534 Health/Human Services Committee	11 E-Mail: Neustis@hhh.umn.edu	1/05
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REVISED MARCH 2004

NAME	REGION	TERM EXPIRES
Mark Hughes 739 Larson Lane Shoreview, MN 55126-2047 H - (651) 484-9235 O - (651) 642-4188 Accessibility/Infrastructure Committee	11 E-Mail: mhughes@hbi.com	1/04
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NAME	REGION	TERM EXPIRES
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David Schwartzkopf 331 Wimbledon Hills Drive SW Rochester, MN 55902-4134 H - (507) 285-0516 (H) E-Mail: schwartzie@qwest.net O - (651) 379-5875 (O) E-Mail: daschwartzkopf@goodwilleasterseals.org Executive Committee Education/Employment Committee	10	1/05
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John Tschida 1999 Bordner Place St. Paul, MN 55116-2504 H - (651) 696-9048 O - (763) 520-0533 Interim Chair Executive Committee Accessibility/Infrastructure Committee	11 E-Mail: johnt@courage.org FAX # (763) 520-0562	1/05
Brian Wagner 2006 Meadow Lane NE Alexandria, MN 56308 H - (320) 762-0580 O - (320) 762-2503 Executive Committee Chair: Education/Employment Committee	4 **(E-MAIL SHORT MEMO'S ONLY)** E-Mail: bewagner99@hotmail.com	1/04

NAME	REGION	TERM EXPIRES
Sheila Wieser 610 Hillcrest Ave. La Crescent, MN 55947 H – (507) 895-2856 O – (608) 782-6410	11 E-Mail: sheila@lacrossemonument.com	1/07
Rachel Wilcox 218 7th St. East, #312 St. Paul, MN 55101-2381 H - (651) 227-6349 Executive Committee Health/Human Services Committee	11 E-Mail: racwill2003@yahoo.com	1/04

MINNESOTA STATE COUNCIL ON DISABILITY
SPECIAL LIAISONS
JANUARY 2003

NAME	AGENCY	ADDRESS	PHONE NUMBER
MaryJo Erickson	Dept. of Employee Relations	200 Centennial Office Building 658 Cedar Street St. Paul, MN 55155	651/297-4042
Bernie Johnson	Special Assistant Attomey General	525 Park Street, Suite 200 St. Paul, MN 55103	651/296-1801
Dennis Munkwitz	Dept. of Finance	400 Centennial Office Building 658 Cedar Street St. Paul, MN 55155	651/296-8510

MINNESOTA STATE COUNCIL ON DISABILITY
EX-OFFICIO
JANUARY 2004

NAME	AGENCY	ADDRESS	PHONE NUMBER
	MN Board on Aging	Human Services Building 444 Lafayette Road St. Paul, MN 55155	
Neil Doughty MSCOD Health/Human Services Committee	Dept. of Human Services	444 Lafayette Road St. Paul, MN 55155	651/296-2113
John Fillbrandt MSCOD Health/Human Services Committee	Dept. of Human Services	444 Lafayette Road St. Paul, MN 55155-3814	651/582-1910
Tom Gottfried MN MSCOD Accessibility/Infrastructure Committee	Dept. of Transportation	210 Transportation Bldg. 395 John Ireland Blvd. MS430 St. Paul, MN 55155	651/296-0377
John Hurley MSCOD Health/Human Services Committee	Dept. of Health, MN Children with Special Needs	85 East 7th Place, Suite 400 St. Paul, MN 55101	651/281-9951
Steven Lapinsky MSCOD Education/Employment Committee	MN Dept. of Human Rights Disability Unit Supervisor	190 East 5th Street, Suite 700 St. Paul, MN 55101	651/296-5223
Linda Lingen MSCOD Health/Human Services Committee	State Services for/Blind	2200 University Avenue St. Paul, MN 55104	651/642-0504
	Dept. of Trade And Economic Development	500 Metro Square Bldg. 121 East 7th Place St. Paul, MN 55101	
Wende O'Brien MSCOD Health/Human Services Committee	Dept. of Revenue Affirmative Action Officer	600 North Robert Street St. Paul, MN 55101	651/556-6010
Steve Serkland MSCOD Education/Employment Committee	Dept. of Economic Security	390 North Robert Street 5th Floor St. Paul, MN 55101	651/296-7869
Cindy Shevlin-Woodcock MSCOD Education/Employment Committee	MN Dept. of Children, Families and Learning, Special Education Div.	1500 HWY 36 West Roseville, MN 55113	651/582-8656
Colleen Wieck (Bonnie Jean Smith attends on her behalf)	Dept. of Administration, Developmental Disabilities Council	300 Centennial Office Building 658 Cedar Street St. Paul, MN 55155	651/296-9964

MINNESOTA AREA COUNCILS ON DISABILITY
JANUARY 2004

Alexandria Area Council on Disability
Brian Wagner, Chair
2006 Meadow Lane NE
Alexandria, MN 56308

Mower Council for the Handicapped
Mr. Gary Jacobson, Chairperson
111 North Main, #272
Austin, MN 55912

Chisago County Disabled Support Group
Gary Beringer, Chair
30930 Finch Avenue, #3
Stacy, MN 55079 (320) 253-0765
E-mail: gerber2578@aol.com

North Suburban Consumer Advocates For the Handicapped, Inc.
Mr. Jesse Ellingworth, Executive Director
1201 - 89th Avenue NE, Suite 345
Blaine, MN 55434

St. Paul Mayor's Advisory Committee For People with Disabilities
Mark Hughes & Walter Waranka
Co-chairs
3415 University Avenue SE
Minneapolis, MN 55414
E-mail: "Mark Hughes"<mhughes@hbi.com>

Minneapolis Advisory Committee on People with Disabilities
Margot, Imdieke Cross, Chair
121 East 7th Place, Suite 107
St. Paul, MN 55101

Disabilities Council, St. Cloud Area
Judy Moening, Chair, UCP Central MN
510 – 25th Avenue North
St. Cloud, MN 56303 (320) 253-0765
E-mail: ucpcentralmn@astound.net

Metro Area Mayor's Committee on Employment of People w/Disabilities
Tom Thompson, Chair
(Serving Moorhead/Dilworth, MN and Fargo/West Fargo, ND Regions)
P.O. Box 162
Fargo, ND 58107-0162

Duluth Commission on Disabilities
Joyce Blodgett, Acting Chair
132 West Toledo
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AREA LIAISONS

Wadena Area Liaison
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MINNESOTA STATE COUNCIL ON DISABILITY STAFF MEMBERS

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(Accessibility/Infrastructure Specialist)

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(Education/Employment Specialist)

Joan Willshire – (651) 296-1743
(Executive Director)

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REVISED: MARCH 2004

MSCOD
Minnesota State Council
On Disability

PUBLICATIONS

- **Building Access Survey**
  A comprehensive building access survey based on the Minnesota State Building Code

- **Responding to Disability: A Question of Attitude**
  A disability awareness booklet

- **Transition: School to Adult Life**
  A guide to the provisions in law for students with disabilities age 14-21/22

- **2005 Disability Legislative Forum**
  A summary of presentations

- **Know Your Rights and Responsibilities:**
  A comprehensive summary of disability rights laws

These publications can be obtained at:
www.disability.state.mn.us

CURRENT LEGISLATIVE ISSUES FOR PEOPLE WITH DISABILITIES

2005 Disability Legislative Forum Summary

MSCOD
Minnesota State Council
On Disability

2005 DISABILITY LEGISLATIVE FORUM

Tuesday, December 7, 2004

A Virtualpresence Communication Event

Presented by:
The MINNESOTA STATE COUNCIL ON DISABILITY
The MINNESOTA CONSORTIUM FOR CITIZENS WITH DISABILITES
In Partnership with:
MINNESOTA CENTERS FOR INDEPENDENT LIVING

2005 DISABILITY LEGISLATIVE FORUM

Tuesday, December 7, 2004

A Virtualpresence Communication Event
Interconnecting with Minnesota County sites in:
Brainerd, Bemidji, Duluth, LeCenter, Moorhead, Redwood Falls, Rochester, Roseville, St. Cloud, Thief River Falls, Willmar

Presented by:
The MINNESOTA STATE COUNCIL ON DISABILITY
The MINNESOTA CONSORTIUM FOR CITIZENS WITH DISABILITES (MN-CCD)
In Partnership with:
MINNESOTA CENTERS FOR INDEPENDENT LIVING

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MINNESOTA CONSORTIUM FOR CITIZENS WITH DISABILITIES
LEGISLATIVE PROPOSALS

Relocating people with Disabilities from Nursing Homes into the community

- MN-CCD supports the development of a statewide plan and system for helping people with disabilities under the age of 65 to move from nursing facilities into more appropriate, less-costly community-based settings.
- MN-CCD supports a system to quantify, update and track county data on the number of individuals in Minnesota's nursing home facilities that have actually requested relocation services.
- MN-CCD supports the need for a statewide coordinated commission focused on planning and monitoring the myriad services and programs aimed at helping people with disabilities live in more independent settings.

More Choices in Case Management Providers

- MN-CCD supports consumers having more choice in selecting their initial provider for case management or relocation coordination services.
- MN-CCD supports expanding relocation service coordination through new partnerships with community service providers, this could also enhance the state's capacity to provide culturally competent and language-specific relocation services.

Greater Flexibility in Funding for Community Transitions

- MN-CCD supports funding for upfront relocation costs such as damage deposits for rental units or basic housing-related needs such as furniture and household items.
- MN-CCD supports the provision of opportunities for consumers to see firsthand alternative community living arrangements.

Continuity of Case Management During and After the Transition Period

- MN-CCD supports coordination of case management services among nursing home, transition and community caseworkers in order to provide a successful blend of health care and community supports necessary in order for individuals to achieve independence in their communities.

Bonding for Development of Supportive Housing and Services

- MN-CCD supports a bonding request in the 2006 Legislative Session for the MN Housing Finance Agency (MHFA), other agency partners and community housing developers, to begin developing supportive housing for working-age individuals wanting to move from nursing homes to less-restrictive community settings.

Housing Opportunities for People with Disabilities in "Assisted Living"

- MN-CCD supports the assisted living option for people with disabilities when this environment does not restrict individual choice in living arrangements: Individuals have the ability to live in the least restrictive setting; shall be able to contract with another provider of personal care services when individuals are not able to receive these services through the assisted living provider.

Transit Services for People with Disabilities

- MN-CCD supports a dedicated funding source for Metro Mobility.
- MN-CCD supports Medical Assistance transportation as a back-up option for para-transit services in Greater Minnesota.
- MN-CCD supports directing some individuals to less specialized and less expensive forms of transportation as an alternative to Special Transportation Services (STS) provided that: quality and safety remain a priority; appeals for re-certification for STS services are conducted by an independent third party and, the state continues to monitor and evaluate the brokerage system.
- MN-CCD supports a plan that would increase per diem transportation rates that more closely relate to the cost of providing this service to consumers with developmental disabilities: this plan would also reduce the rate-disparity among day training and habilitation (DT & H) programs for providing this service.
- MN-CCD supports a five percent increase per year for Greater Minnesota transit over the next four years in order to expand service and the implementation of a demonstration project utilizing special transportation services (STS) as a back-up transit system for riders to use when public transit is not available.
- MN-CCD supports codifying disability parking categories and related fees in statute; clarify in statute the definition of a disability parking space which includes the transfer space, requiring the person with the disability to exit a vehicle parked in disability parking, and

permitting the Minnesota State Council on Disability to report suspected violators and strengthening enforcement language.

Preventive Measures for Conditions Unrelated to Disability

- MN-CCD supports incentives created that would encourage people with disabilities to have an annual wellness exam conducted by a physician other than the one they see that specializes in their disability.
- MN-CCD recommends that the state require that no person in Minnesota should be denied long-term care insurance based on disability. In addition, the state should reduce the person with a disability's state tax liability by the same amount paid for long-term care insurance.

Medical Assistance (MA)

- MN-CCD supports raising the income standard for seniors and persons with disabilities who need MA when they are unable to work to 100 percent of poverty ($776) for a single adult.
- MN-CCD supports raising the asset limits to equal the current state prescription drug program limits of $10,00 for a single adult and $18,000 for a married couple.
- MN-CCD supports doubling the personal needs allowance to equal $150 per month.

Employment

- MN-CCD supports increased Extended Employment program reimbursement rate and total funding to account for lost buying power and to address a growing waiting list.
- MN-CCD supports elimination of the waiting list for Rehabilitation Services by increasing appropriations, identifying additional ways to maximize matching funds/by examining the rehabilitation program to identify ways to increase efficiencies in service delivery in order to maximize the number of people with disabilities served with existing dollars.
- MN-CCD supports greater coordination and communication between DHS and DEED to ensure the maximization of MA and Rehabilitation Services matching dollars and coordination of all employment programs for individuals with disabilities.

Assistive Technology

- MN-CCD proposes a $300,000 general appropriation to match $1.5 million in federal funds: Authorize a one-time special appropriation to provide a portion of the state/local match necessary to receive $2.2 million in federal funds. (Federal funds were approved in 2003) The organization administering the programs raises the remainder of the required match, $218,000.

Dental Access

MN-CCD recommends a study on the barriers of access to dental services for people with disabilities including but not limited to physical access, willingness of dentists to serve people with disabilities enrolled in public programs and, reimbursement rates for dentists.

MN Prescription Drug Program

- MN-CCD will advocate for no substantial premium changes to people enrolled in the Medical Assistance for Employed People with Disabilities (MA-EPD) program.
- MN-CCD will advocate repealing the Medicare Part B premiums instated last year.
- MN-CCD will advocate that any savings gained by modifying or eliminating the state prescription drug program shall be diverted to other programs serving seniors and people with disabilities.
- MN-CCD will advocate that restricting of certain drugs should be done very carefully if it would negatively effect response to treatment, cause relapse or delay recovery.

Choice of Case Management Provider

- MN-CCD supports a change in Minnesota law to allow payment for service coordination through the MA program. Vendors of service coordination would be MA providers who meet qualifications and bill on a unit basis.

Minnesota Disability Health Options

- MN-CCD supports a thoughtful-measured expansion of voluntary care coordination for people with physical disabilities ages 18-64 still on a fee-for-service system.
- MN-CCD also supports the development of a care coordination system for people with other types of disabilities.

MA Co-Payments/Dental Coverage

- MN-CCD supports language contained in Senate File 1760 during the 2004 session that resolved the issues of cost sharing policies that cause substantial reduction in health care use and lead to adverse health consequences among poorer individuals.

Health Care Access

- MN-CCD supports the continued use of the Health Care Access Fund (HCAF) as a funding source for needed health care programs including MinnesotaCare.

MinnetotaCare (MnCare)

- MN-CCD supports first, the elimination or modification of the $5,000 cap for people on MnCare or secondly, reasonably increased premiums in order to eliminate the cap. MN-CCD also supports the reinstatement of cuts to critical services through MnCare including mental health services.

Medical Assistance for Employed Persons with Disabilities

- MN-CCD proposes repealing the requirement that MA-EPD enrollees pay the Medicare Part B if they are eligible for Medicare and repealing the requirement that enrollees must earn $65 a month and count any earned income.

Parental Fees

- MN-CCD would make adjustments in the Federal Poverty Guideline brackets that would lower fees, increase the in-home deduction and change the treatment of child support paid to a deduction from the fees, as was the law in 2003.

Support for Families with Disabled Family Members

- MN-CCD supports the restoration of MN Family Investment Program Grants (MFIP) to the level before the 2003 legislative session reductions.

General Assistance Medical Care (GAMC)

- MN-CCD supports reinstatement of GAMC for people between 75% to 175% of poverty and reinstatement of mental health benefits.

Extended Employment for People with Serious and Persistent Mental Illness (EE-SPMI)

- MN-CCD supports reinstatement of $394,000 for EE-SPMI, a unique and successful program providing supports to working individuals with serious and persistent mental illnesses to provide long term job retention.
- MN-CCD supports continuity of drug treatment for individuals with mental illness using brand name drugs, or a statutory change to prohibit the transfer to generic alternatives when a successful course of treatment is in progress.

Provider Rates and Support Staff Compensation

- MN-CCD believes rate increases are critical to quality of life and safety for people with disabilities.

Home Care Waivered Rates for Skilled Services

- Medicare certified home care providers cannot afford to continue delivering skilled care visits to clients in their own homes: Rates need to be re-evaluated and adjusted.

Services to People on Waiting Lists and Elimination of Caseload Caps

- MN-CCD proposes to eliminate limits and capitations placed on Medical Assistance Home and Community Based Waivers for disabled individuals under the age of 65, specifically the TBI, CADI and MR/RC waivers.
- On March 1, 2004 the state transferred responsibility for CADI, CAC and TBI waiver dollars to counties under what is referred to as the Aggregate Management System (AMS). The three primary issues of the use of the AMS are: insufficient funding for new recipients, counties inability to properly utilize the tools given to manage their budgets and to provide necessary funding for services to new recipients and, counties have not yet developed policies and criteria for implementation of the aggregate waiver.

Group Residential Housing (GRH)

The 2003 Minnesota Legislature authorized the Department of Human Services to apply for a federal waiver amendment to transfer the GRH supplementary rate expenditures to Home and Community Based Service waivers.

- MN-CCD recommends that the transfer of funding from the GRH supplementary rate should result in an equal increase in the individual's MA rate.
- MN-CCD recommends that clear safeguards be put in place so that services for people will not erode over time as counties struggle to stay within their state-set waivered services budgets.
- MN-CCD recommends that GRH payments for new development be established on actual costs.

Redesigning Services to Maintain Essential Community Supports

- Some system elements must be redesigned.
- MN-CCD calls for a partnership of all stakeholders to analyze system redesign options and recommend changes.
- MN-CCD recommends that the legislature adopt language prohibiting the State of MN from entering into a block grant agreement without the Legislature affirming such action by adopting a resolution in support of such action by a super majority.

Dedicating Federal Money to Waiver Management

- MN-CCD recommends that, because many of the activities for persons with disabilities generate federal revenue from the Medicaid program, the management of these programs would be improved if some of the revenue were used to manage the programs that generate the revenue.

Regionalizing the System

- MN-CCD supports reducing the number of separate entities that administer the home and community waiver and other disability programs: This could be accomplished by counties in a region entering into agreements and sharing responsibilities and resources in order to better serve all eligible persons in an area.

Waiver Maximizing Current Resources

The MN-CCD recommends that the following issues be evaluated in a process that includes all stakeholders:

- Privatization of some case management/service coordination and the delivery of direct supports and services
- Without adequate funding for the MR/RC waiver, people on waiting lists are not getting the services they need, providers have difficulty keeping homes open, and counties have difficulty managing allocations without fear of financial liability.

Special Education

- MN-CCD supports the reinstatement of the 4.6% annual special education growth factor in the K-12 funding formula and funding it accordingly.
- MN-CCD recommends that the state's aversive and deprivation intervention laws and rules be reviewed and clarified and that training targeted to administrators, teachers, related services personnel and parents at the local district level be provided.
- MN-CCD recommends that publishers selling textbooks be required to abide by the voluntary standardized format for electronic files so students with disabilities can have timely access to textbooks and classroom materials.
- MN-CCD recommends that college graduates who become certified and practicing teachers of students who have emotional-behavior disorders would be eligible to have a portion of college loans forgiven based on years of service.
- MN-CCD recommends a provision in statute or an amendment to existing rules affecting individuals who are pursuing licensure as a school administrator to participate in initial and on-going training on recognizing signs of potential mental illness as well as autism spectrum disorders among students.
- MN-CCD recommends that all new school construction follow acoustics standards developed and approved by the American National Standards Institute (ANSI) in order that children would be better able to hear in the classroom and test scores would improve.
- MN-CCD recommends establishing a more coordinated approach among schools and community based mental health care providers in addressing the needs of children with mental health disorders.

MINNESOTA ASSOCIATION OF CENTERS FOR INDEPENDENT LIVING (MACIL)

The primary focus of the Minnesota Association of Centers for Independent Living (MACIL) for the 2005 legislative session will be three fold. First, MACIL will provide information to new and returning Legislators to ensure their thorough understanding of the role and function of Centers for Independent Living. Second, thorough one-on-one meetings and testimony to appropriate committees, MACIL will promote its continued visibility among Legislators. And, finally, MACIL will monitor the agenda and discussions of appropriate finance committee, and provide related information when requested, to ensure continued funding for Minnesota's CILs.

MACIL also supports the efforts of the Minnesota CCD.

HAVA EQUIPMENT BILL

The Minnesota State Council on Disability will continue to partner with the Secretary of State's Office regarding the HAVA Equipment Bill. The proposed legislation would authorize the purchase of accessible voting equipment for each polling place throughout the state.

HENNEPIN COUNTY PROPOSED POSITIONS ON HUMAN SERVICES FOR 2005 MINNESOTA LEGISLATIVE SESSION

A. Hennepin County Board supported the following legislative actions:
   1. Assure that changes in the TANF don't significantly reduce the percentage of the funding that is earmarked for Hennepin County

B. County Board will consider on November 30th whether Hennepin County should initiate action on the following:
   1. Reinstate eligibility levels for child care assistance and establish payments levels that will assure the availability of needed child care providers
   2. Promote legislation that would provide a consistent statewide policy on smoking in restaurants.

C. On December 14th, the County Board will consider whether Hennepin County should support the efforts of others relative to the following issues:
   1. Raise the cigarette tax rate as a strategy to promote a reduction in youth smoking and provide a funding source for health programs for youth
   2. Eliminate the county share of the cost of RTC's, ICF/MR's, and IMD's
   3. Expand eligibility for publicly funded health programs in order to assure that individuals receive the medical care needed to assure that they are able to maintain employment status,
   4. Assure adequate funding for drugs for persons with AIDS so that they receive adequate treatment, don't become drug-resistant and thus create a major public health threat. As one component of that effort, assure that the drug rebates received by the state for AIDS drugs are targeted for that program.
   5. Protect vulnerable low-income individuals from excessively high fees and interest rates that are inconsistent with limits on loan rates within MN banks (Rapid Refund Loans or Refund Anticipation Loans).
   6. Provide adequate funding for individuals that choose to utilize Consumer Directed Community Services.
   7. Support PMAP rolling eligibility in order to promote ongoing medical care for high-risk populations and reduce extra paper work.

ASSISTIVE TECHNOLOGY OF MINNESOTA

Special Request, General Fund
Funding to Support Federal Grants Establishing Low Interest Loans
For People with Disabilities

Assistive Technology of Minnesota, ATMN, received two federal grants in late 2003 to develop low interest loan programs for people with disabilities. The programs will support the purchase of employment- related equipment and assistive technology, (AT), devices /services. In Minnesota, ATMN is the only statewide nonprofit to provide alternative financing options specifically for the purchase of AT and employment related equipment. ATMN is required to raise a local match as a condition of receiving the federal funds.

The Alternative Finance Program, funded in part by the US Department of Education provides over 1.2 million in federal support to expand ATMN's Micro-Loan Program. When fully funded, the new program have set aside over 1.7 million to use as loan guarantees and to operate the program for many years in the future. ATMN is seeking assistance from the State of MN through a one-time request to the 2005 Legislature for a $250,000 appropriation to assist us in reaching the required local match of $423,000.

Access to Telework-MN is a unique employment option that assists individuals with disabilities in the development and long-term sustainability of careers by providing low interest loans for the purchase of equipment. The goals of "Telework" are to increase employment outcomes with a focus on working from home, creating or sustaining business ownership and self-employment. The federal government awarded Assistive Technology of MN a grant through the US Rehabilitation Services Administration to develop and administer Access to Telework. The award of $864,000 requires Minnesota to raise a local match of $95,000. ATMN is seeking a one time general appropriation from the State of Minnesota for $50,000 for the local match requirement.

In 2004, ATMN's requests to the State Legislature for both projects were approved only to be deferred when the session concluded before completing the final budget bills. ATMN will re-introduce the bill in the upcoming session, seeking full funding for the programs.

MINNESOTA MENTAL HEALTH LEGISLATIVE NEWTORK

The major theme of the 2004 legislative session was what did not happen. The program and funding reductions that occurred in the 2003 legislative session were not, for the most part, reversed in the 2004. This has created painful situations for consumers who have disabilities related to serious mental illness.

During the 2004 session, the Minnesota legislature:

- did not pass a $20 million dollar bonding bill to eliminate chronic homelessness;
- did not resolve the $160 million budget deficit for the 2004-2005 biennium, and so the Governor used executive authority and administrative reductions to balance the budget, including withholding transfers to the Health Care Access Fund (HCAF). (The HCAF was created to provide funding for MinnesotaCare, a subsidized health care program for low-income Minnesotans who do not qualify for Medical Assistance. Beginning in 2006, HCAF could have a deficit.)

During the 2003/2004 session, the Mental Health Legislative Network saw mixed successes in achieving our agenda:

- Co-payments on medications were not eliminated, not even elimination of co-pays on medications treating bipolar disorder and depression.
- We were unable to designate $20.7 million dollars in CCSA block grants specifically for children's mental health treatment.
- Extended Employment Projects for people with serious and persistent mental illness were not restored.
- Funding for Bridges Housing and other subsidized housing was not restored.
- The limited benefit set under GAMC and MinnesotaCare was not established, and we were unable to remove the $5,000 cap on non-inpatient services under MinnesotaCare.
- MA-EPD fees were increased.
- $125 per month MFIP cuts remain for parents caring for a child with a disability remains, although it could have gone higher.
- $500 per year limit on dental coverage remained.
- Health Care Continuity – We successfully passed language that assures that people get continued mental health coverage when they convert to other plans, or know when their benefits are changing and what else is available.

During the 2005 session, the Legislative Network plans to revisit many of these items, as well as propose some new ones, in order to improve services for people with disabilities related to mental illness. Key among the new items will be support of: Appropriate sections of recommendations from the Minnesota Mental Health Action Group (legislation to be proposed by DHS); support of the Minnesota Aids Project constitutional amendment declaring that all Minnesotans have the right to access affordable health care; and ensuring that restrictions not be imposed that prevent a person from accessing the medications that work best for a consumer. A more complete review of the Network's agenda will occur on December 7th.

MINNESOTA HOMECARE ASSOCIATION

Home Care Medical Assistance (MA) and Waivered Reimbursement Rates

Background: Minnesota reimbursement rates for Home Care services i.e. Skilled Nursing, Physical Therapy, Occupational Therapy, and Speech Therapy visits have consistently lagged far behind other Mid-western states. From 1985 until 1994, Home Care providers received No reimbursement rate increase. This included No COLA increase provided to other health care services. In 1994 some (but not all) services received a 3% increase. In 1997 only the personal care assistant services received a 1.5% increase. Home care services related to physical therapy, occupational therapy and speech therapy received No increase during this entire 14 year period.

Problem: Skilled visit reimbursement rates for MA and waivered services cover only 48% of the cost. In other Mid-western states, MA/waiver reimbursement rates are comparable to Medicare cost-based reimbursement rates. Lack of increases for 14 years has resulted in service rates that are dramatically lower than rates in surrounding states. Reimbursement rates for comparable services in our surrounding states are 30% to 50% higher than in Minnesota.

Many county public health care providers and several hospital-based providers no longer serve patients on the MA waivered programs due to low MA reimbursement rates. Additionally, many private Home Care providers are in the process of re-evaluating the viability of their MA and waivered services business.

Some of Minnesota's most vulnerable citizens, those with acute or chronic disabling conditions will not receive essential Home Care services. The ensuing long term financial consequences to the state will be disastrous.

Solution: Evaluate and increase reimbursement rates. In order for home care providers to continue delivering services to individuals on Medical Assistance, CAC, CADI, TBI, EW and AC, visit rates must be increased. Home care providers cannot afford to continue providing essential services to clients in their own homes without adequate reimbursement. Fewer home care services will most assuredly result in increased use of expensive alternatives such as a hospital or nursing home.

Recommendation: Increase the reimbursement visit rate to cover the cost for services.

	Skilled Nursing Visit	Physical Therapy Visit	Occupational Therapy Visit	Speech Therapy Visit	Home Health Aide Visit
Minnesota Average Costs *	$140.58	$104.84	$108.89	$143.53	$55.96

*Minnesota Average Costs data is based on 142 cost reports from both freestanding and hospital based home health agencies in Minnesota. Source: National Association for Home Care & Hospice, 2002 - 2003

Current Reimbursement	Skilled Nursing Visit	Physical Therapy Visit	Occupational Therapy Visit	Speech Therapy Visit	Home Health Aide Visit
Iowa	$85.23	$98.30	$98.30	$98.30	$45.05
Wisconsin	$84.28	$80.52	$82.67	$85.35	$39.71
North Dakota	$89.94	$89.94	89.94	$89.94	$60.00
Minnesota	$63.58	$59.65	$60.87	$60.55	$48.79

For more information, contact Jeff Bangsberg, Government Relations Director, Minnesota HomeCare Association at 651-635-0607 or jbangsberg@mnhomecare.org.

REPORTS AND STATISTICAL INFORMATION

2000 Census Analysis
Seniors With Disabilities in 2030

MSCOD
Minnesota State Council
On Disability

MNNESOTA STATE COUNCIL ON DISABILITY
CENSUS INFORMATION

INTRODUCTION

The MSCOD has analyzed disability-related information in the **2000 Census** and the Council's observations are found below. The census information comes from the *Census Long Form*, which was completed by approximately one in every seventeen individuals.

In addition to a short summary of "observations," the MSCOD has produced a two-part document, which extracts disability-related information such as:

- Disability status
- Employment rates
- Percentage by type of disability
- Disability and poverty
- Disability and educational attainment.

2000 CENSUS BOOKLET ONE CONTAINS: NUMBER AND PERCENTAGES OF EMPLOYED PERSONS WITH DISABILITIES BY STATE, COUNTY, METRO AREAS, REGIONAL DEVELOPMENT REGIONS AND OTHER STATES; POPULATION LIVING IN GROUP QUARTERS; GROUP QUARTERS POPULATION BY COUNTY AND COMPARISON OF 1990 AND 2000 NUMBERS.

2000 Census Booklet Two contains: various tables of demographic information regarding persons with disabilities; age by types of disability, by state and by county (a duplicated count of persons with disabilities by disability type, i.e. persons with more than one disability are counted under each category of disability which they report); non-duplicated numbers of persons with disabilities by county.

The U. S. Census Bureau uses its own definition of disability (see below). There is no "universal" definition. Many definitions exist, each specific to a particular law, program, service or survey. The census definition differs from that used in the **Americans with Disabilities Act** and the **Minnesota Human Rights Act**, as well as many other definitions used in other surveys of the population of persons with disabilities. Therefore, the census figures may differ from other surveys on the prevalence of disability. Additionally, the census uses a self-reporting method.

It should also be noted that nursing homes are considered "institutions" for purposes of the census, while intermediate care facilities for persons with mental retardation (ICFs/MR) are considered non-institutional quarters. In state law, however, an ICF/MR is the nursing home equivalent for persons with mental retardation and related conditions. The consequence of this census definition of "institution" is that people living in long term care facilities are considered to be "institutionalized" and therefore are not included in census observations concerning poverty status, employment status, disability etc.

2000 CENSUS OBSERVATIONS

DISABILITY STATUS OF CIVILIAN NON-INSTITUTIONALIZED POPULATION

The proportion of non-institutionalized Minnesotans age 5 and over with a disability is approximately 15 percent. Nationally, this is on the low end of the spectrum compared to states like Arkansas, Kentucky, Mississippi and West Virginia where approximately 24% of the population age 5 and over have a disability. In Minnesota, as with the rest of the nation, the incidence of disability rises sharply with age.

DISABILITY STATUS

SUBJECT	NUMBER	PERCENT
Population age 5 – 20	1,168,374	100%
With a disability	82,719	7.1%
Population age 21-64	2,803,699	100%
With a disability	392,313	14.0
Population 65 & over	554,138	100%
With a disability	204,204	36.9%

EMPLOYMENT RATE #1 IN NATION BUT LAGS BEHIND RATE FOR THOSE WITHOUT DISABILITIES

In the age group of working adults (21-64), Minnesota has the highest percentage of people with disabilities in the workforce in the nation at 65%, compared to a national average of 57%. However, those rates compare to an employment rate of 84.3% in Minnesota, and 77.2% nationwide, for people without disabilities.

SUBJECT	NUMBER	PERCENT
MN pop. age 21-64	2,803,699	100%
With a disability	392,313	14.0
Percent employed		65%
No disability	2,411,386	86%
Percent employed MN w/no disability		84.3%
Percent employed U.S. with disability		56.6%
Percent employed U.S. w/no disability		77.2%

POPULATION DISTRIBUTION

While survey procedures and definitions are different, contrary to the 1978 Household Survey done by the Minnesota Department of Economic Security, metropolitan areas in 2000 did NOT have a larger percentage of persons with disabilities.

However, within the Twin City metropolitan area, there is a higher concentration of persons with disabilities in the center cities.

PEOPLE WITH DISABILITIES HAVE A MUCH HIGHER RATE OF POVERTY THAN OTHER MINNESOTANS

People with disabilities are more likely to live in poverty than people without disabilities, especially in the age group of working adults (age 21-64) where the incidence of poverty is about 2½ times greater for persons with disabilities of both genders. The incidence of poverty for all age groups in the 2000 Census is:

	MALE		FEMALE	
Age	Disabled in Poverty	Not Disabled in Poverty	Disabled in Poverty	Not Disabled in Poverty
5-15	15%	9%	17%	9%
16-20	15%	11%	21%	15%
21-64	13%	5%	16.5%	6%
Over 65	7.5%	4%	15%	7.5%

(These figures are for people for whom the poverty status has been determined which are 4,468,233 of 4,526,211 people).

PEOPLE WITH DISABILITIES LESS LIKELY TO FINISH HIGH SCHOOL OR FINISH HIGHER EDUCATION DEGREE

For people 18 to 34 years, 18% of males with a disability are not high school graduates as compared with 8% of males without a disability. And, 14% of females with disabilities are not high school graduates compared to less than 6% percent of females without disabilities.

Just over 7.5% of males with a disability have a bachelor's degree compared to 16.5% of non-disabled males that have a bachelor's

degree. And, 8% of females with a disability have a bachelor's degree and 19.5% of non-disabled females have one.

Fewer than 14% of males with a disability are in college or graduate school compared to 20% of non-disabled males in college or graduate school. And, 17.5% of females with a disability are in college or graduate school compared to about 23% of non-disabled females.

TYPES OF DISABILITIES

Of children (age 5 to 15 years) with a disability 66.7% have a mental disability, almost 10.8% have a self-care disability, over 11.2% have a sensory disability and 11.2% have a physical disability.

Of people age 16 to 64 with a disability, 36.5% have an employment related disability, 19.8% have a physical disability, 16.4% have a go-outside-the-home disability, 14.1% have a mental disability, 7.5% have a sensory disability, and, 5.3% have a self-care disability.

Of the population over 65 years of age and over, 35.3% have a physical disability, 25% have a go-outside-the-home disability, over 18% have a sensory disability, 11% have a mental disability and, 10% have a self-care disability.

DEFINITIONS

Disability Status - People 5 years old and over are considered to have a disability if they have one or more of the following: (a) blindness, deafness, or a severe vision or hearing impairment; (b) a substantial limitation in the ability to perform basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying; (c) difficulty learning, remembering, or concentrating; or (d) difficulty dressing, bathing, or getting around inside the home.

In addition to the above criteria, people 16 years old and over are considered to have a disability if they have difficulty going outside the home alone to shop or visit a doctor's office, and people 16-64 years old are considered to have a disability if they have difficulty working at a job or business.

CENSUS QUESTIONS

The questions asked to determine disability status are questions 16 and 17, as stated below.

16. Does this person have any of the following long-lasting conditions?

a. Blindness, deafness, or a severe vision or hearing impairment?
Yes No

b. A condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying?
Yes No

17. Because of a physical, mental, or emotional condition lasting 6 months or more, does this person have any difficulty in doing any of the following activities?

a. Learning, remembering, or concentrating? Yes No

b. Dressing, bathing, or getting around inside the home? Yes No

c. (Answer if this person is 16 YEARS OLD OR OVER.) Going outside the home alone to shop or visit a doctor's office? Yes No

d. (Answer if this person is 16 YEARS OLD OR OVER.) Working at a job or business?
Yes No

DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION

State	5-20 % With Disability	21-64 % With Disability	21-64 % With Disability Employed	21-64 % With No Disability Employed	Over 65 % With Disability
United States	8.1	19.2	56.6	77.2	41.9
Alabama	9.0	23.2	50.6	74.8	49.5
Alaska	6.9	15.6	55.3	75.7	46.2
Arizona	8.0	19.4	56.9	74.2	39.7
Arkansas	9.4	23.4	51.6	76.7	48.9
California	7.5	20.0	54.9	73.1	42.2
Colorado	7.4	15.9	61.9	81.2	40.0
Connecticut	7.6	16.8	63.1	80.3	37.0
Delaware	8.9	18.0	60.2	79.8	37.7
District of Columbia	10.0	21.9	52.8	73.4	42.5
Florida	8.7	21.9	58.3	74.9	39.5
Georgia	8.2	19.9	57.3	77.6	47.5
Hawaii	6.6	17.7	58.8	75.9	40.6
Idaho	7.2	16.7	58.3	78.8	42.5
Illinois	7.7	17.1	57.4	77.5	40.5
Indiana	8.3	18.5	60.8	80.2	42.6
Iowa	7.3	15.2	63.0	84.0	37.8
Kansas	7.2	16.8	62.0	82.1	41.5
Kentucky	9.0	24.0	46.9	76.5	49.3
Louisiana	9.3	22.1	51.4	72.7	48.1

State	5-20 % With Disability	21-64 % With Disability	21-64 % With Disability Employed	21-64 % With No Disability Employed	Over 65 % With Disability
Maine	9.0	19.2	54.7	81.6	41.1
Maryland	8.1	17.2	61.7	80.3	39.8
Massachusetts	8.6	17.9	60.0	80.6	37.8
Michigan	8.5	18.1	54.8	77.9	42.3
Minnesota	**7.1**	**14.0**	**65.0**	**84.3**	**36.9**
Mississippi	8.6	24.5	49.1	74.3	51.7
Missouri	8.0	18.2	55.3	80.0	42.6
Montana	7.1	16.9	55.4	79.1	39.6
Nebraska	6.7	15.2	64.9	84.4	37.1
Nevada	7.7	21.8	61.4	74.9	40.6
New Hampshire	8.4	16.1	64.2	83.9	38.5
New Jersey	7.4	17.4	59.4	77.0	38.6
New Mexico	8.1	21.0	53.5	72.4	44.8
New York	8.8	21.0	54.1	74.1	40.3
North Carolina	8.5	20.9	57.9	78.7	45.7
North Dakota	7.2	15.4	64.0	82.7	38.5
Ohio	7.9	17.5	56.0	79.4	41.0
Oklahoma	8.7	21.5	55.2	76.9	46.7
Oregon	8.2	18.0	57.9	78.2	41.5
Pennsylvania	7.5	17.5	54.8	78.3	39.4
Puerto Rico	10.2	28.2	28.3	46.7	59.1
Rhode Island	9.3	19.7	58.4	79.4	40.3
South Carolina	9.0	22.7	55.5	77.1	45.8

State	5-20 % With Disability	21-64 % With Disability	21-64 % With Disability Employed	21-64 % With No Disability Employed	Over 65 % With Disability
South Dakota	6.8	15.6	64.0	83.7	39.5
Tennessee	8.8	21.9	53.2	77.7	47.8
Texas	7.9	19.9	58.3	74.7	44.8
Utah	6.9	15.4	64.2	78.7	39.9
Vermont	8.3	16.2	60.0	83.5	38.6
Virginia	8.1	17.5	58.5	79.8	42.1
Washington	7.7	17.8	57.6	78.1	42.3
West Virginia	9.1	23.8	40.4	71.5	48.6
Wisconsin	7.9	14.9	61.7	83.1	36.5
Wyoming	7.7	16.8	62.0	80.0	39.3

A Citizens League Research Report
Prepared for the Minnesota State Council on Disability

Seniors with Disabilities in 2030

Getting Ready for the Aging Boom

A final report by the Citizens League
Committee on Seniors with Disabilities

Phil Riveness and Emily Anne Tuttle,
Co-chairs

September, 1999

CITIZENS LEAGUE
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Executive Summary

As the 21st century approaches, the aging of the baby boom generation is receiving a great deal of attention. By the year 2030, our society will be much more heavily composed of individuals over the age of 65 than ever before. This demographic shift will have a profound impact on everything from family relations to state budgets.

The purpose of this report is to examine a subset of Minnesota's aging population - those with disabilities, and specifically their service needs in the areas of healthcare, long-term care, housing and transportation. These are crucial components of independent living for a growing population of individuals with both late-life and lifelong disabilities.

This report combines an understanding of those services currently available with what the demographic trends tell us about future demand, and then outlines recommendations for system improvements that will allow the state to better prepare for a growing population of seniors with disabilities.

The state of Minnesota must begin planning now, because it simply cannot continue on its current path. If the spending patterns of the 1990s were to be continued through the year 2030, the growth of our senior population would increase state spending on health and human services to *65 percent* of the total budget.[1]

What is Disability?
There are many different ways to define disability, but perhaps the most common is "the inability to perform at least one task of independent daily living." Today people with disabilities make up a large and diverse group, that includes those with physical and developmental disabilities, speech, hearing and visual impairments, chemical dependency and mental illness.

The Demographics
There is a critical lack of comprehensive, up-to-date statistical data about people with disabilities in Minnesota. The most recent statewide study to collect data about individuals with disabilities in Minnesota was done more than 20 years ago.

However, there is a general consensus that the overall rate of disability in the United States, and most industrialized countries, is declining. Meanwhile, the actual number of people with disabilities is expected to increase due to the dramatic growth of the 65+ population. The number of Minnesotans over the age of 65 with chronic disabilities is expected to almost double from 135,058 in 1995 to 265,207 in 2030.[2]

Conclusions & Recommendations

Conclusion #1: There is an urgent need for more comprehensive, up-to-date information.

There needs to be a current and regularly updated source of demographic information about the number, condition and location of older adults and seniors with disabilities in Minnesota. There also needs to be one comprehensive, reliable source of information about the type and amount of services available to seniors with disabilities. Finally, we need more information about the unique aging process experienced by individuals with lifelong disabilities.

Conclusion #2: In order to meet the needs of a growing and diversifying population of seniors with disabilities, there must be

[1] *Implications for State Spending of Minnesota's Projected Demographic Trends to 2030.* Minnesota Taxpayers Association, 1998.

[2] *Project 2030 Briefing Book*, Minnesota Department of Human Services, 1998.

increased collaboration among the various sectors of the disability community and between the disability community and the senior community.

This increased collaboration and coordination should begin with state agencies. The legislature should consider structural changes in the various state entities that work with seniors and individuals with disabilities in order to better align policy development and service delivery according to a social model of care. The numerous private advocacy and service organizations that address the needs of seniors and individuals with disabilities must also increase their collaboration by sharing information, jointly developing services and better serving people with dual diagnosis.

Conclusion #3: As frequent users of our healthcare system, seniors with disabilities would benefit significantly from an increased emphasis on chronic-care and the continued deinstitutionalization of healthcare delivery.

The healthcare industry must be encouraged to place greater emphasis on chronic care. In order to continue moving towards this goal, information systems will have to be adapted to allow for information sharing between an individual's numerous care providers, while protecting privacy. Additionally, medical education programs must place a greater emphasis on disabling conditions and diseases, geriatrics, chronic care, and aging with a disability, and the social service and health care industries must increasingly incorporate the use of technology beyond the hospital or clinic setting.

Conclusion #4: The long-term care industry has the potential to provide a wide range of individualized services that allow people to continue living independently longer. However, these services need to become more widely available and the industry will have to overcome a long-term labor shortage that is currently expected to last well into the next century.

Long-term care options, such as assisted living services, can, and should, be made more affordable and available, by providing them in existing structures and separating the cost of housing from the cost of services. Long-term care providers should be given greater flexibility to use existing facilities and resources in new ways, in order to better meet the changing needs of seniors. However, even with greater flexibility, the realities of a shrinking workforce will require Minnesotans to increasingly meet the need for long-term care through care networks at the family, community and neighborhood level. Furthermore, long-term care options must become more affordable, and individuals must begin to assume greater responsibility for financing their own long-term care.

Conclusion #5: In order to remain living independently in the community, seniors with disabilities need housing that is accessible, affordable and connected to services.

In order to encourage more accessible development, the guidelines for dispersing grant funds from the Livable Communities Act should be amended to favor programs that include accessible housing. Overall, housing programs funded wholly or in part by public funds should give enhanced consideration to proposals featuring units that are fully accessible and/or have accessibility features. Finally, and perhaps, most importantly, increased efforts must be

made to educate consumers, builders, developers, architects and city planners about the need for accessible, life-cycle housing.

Conclusion #6: While Metro Mobility provides a significant amount of accessible transportation for resi-dents of the Twin Cities, there is a need for additional options that are also affordable and unrestricted

In order to enhance customer service at Metro Mobility, the Metropolitan Council should consider investing in more advanced technology that allows for better vehicle tracking and communication. Additionally, the taxi industry should be brought into the business of providing transportation for seniors with disabilities and existing providers should consider utilizing mixed fleets, in order to serve the community more efficiently.

Conclusion #7: There is a significant need for more comprehensive trans-portation service in Greater Min-nesota.

The MnDOT Office of Transit needs to take a more proactive approach to developing public transit systems in those counties that currently have none. New and existing transportation services need to be more closely aligned with the needs of the customer, in terms of hours and days of operation. In order to better meet the need for transportation to regional centers, the state should provide tangible incentives to encourage the development of multi-county and regional transportation systems in Greater Minnesota.

Introduction

As the 21st century approaches, the aging of the baby boom generation is receiving a great deal of attention. By the year 2030, our society will be much more heavily composed of individuals over the age of 65 than ever before. This demographic shift will have a profound impact on everything from family relations to state budgets.

The task here is to examine a subset of Minnesota's aging population - those with disabilities, and specifically their service needs in the areas of healthcare, long-term care, housing and transportation. These are crucial components of independent living for a growing population of individuals with both late-life and lifelong disabilities.

By combining an understanding of those services currently available with what the demographic trends tell us about future demand, this report outlines recommendations for system improvements that will allow the state to better prepare for a growing population of seniors with disabilities.

In any attempt to plan for the future, there are numerous unknowns. What services will seniors with disabilities want and/or need in the year 2030? What medical conditions or service delivery issues will have been made obsolete by advances in technology? While there are no definitive answers to these question, one of the goals of this report is to stimulate thought and discussion about these issues now instead of waiting for the year 2030 to arrive.

What happens if we do nothing?
Put simply, the state of Minnesota cannot continue on its current path.

- By the year 2030, individuals over the age of 65 will constitute 23 percent of the state's population, up from 12 percent in 2000. The number of seniors with disabilities is expected to almost double to 265,000.[3]

- In 1997, Minnesota spent $221 per capita on the Medical Assistance program for aged and disabled basic care, long-term care facilities, long-term care waivers and homecare. If we were to continue spending the same amount per client through the year 2030, these services would consume $4,128 per capita, *after* adjusting for inflation.[4]

- In 1997, the state spent 19 percent of its total budget on health and human services. If the spending patterns of the 1990s were to be continued through the year 2030, the growth of our senior population would increase state spending on health and human services to 65 percent of the total budget.[5]

Obviously, these budget projections are unsustainable. Yet this report highlights the need for even more comprehensive services in many areas. Therefore, the emphasis must be on more innovative, flexible, locally-controlled and cost-effective ways to provide needed services.

Additionally, it will become increasingly important to prevent as much late-life disability as possible. This will require researching and disseminating information through creative partnerships of public health professionals, community agencies and health insurance organizations.

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[3] *Project 2030 Briefing Book*, Minnesota Department of Human Services, 1998.
[4] *Implications for State Spending of Minnesota's Projected Demographic Trends to 2030.* Minnesota Taxpayers Association, 1998.
[5] *Implications for State Spending of Minnesota's Projected Demographic Trends to 2030.* Minnesota Taxpayers Association, 1998.

DISABILITY RIGHTS LAWS

Minnesota State Council
On Disability

MSCOD
Minnesota State Council On Disability

FACT SHEET ON DISABIITY PARKING

APPLICATION PROCESS

To apply for a disability parking certificate, the person with a disability fills out "Section A" of the application form. If necessary someone may assist in the completion of this section of the form. To apply for Disability Parking license plates, an application form may be completed when the license tabs are due for renewal. The applicant's Minnesota physician, physician's assistant, registered nurse practitioner or chiropractor (Health Professional) then needs to complete and sign "Section B" of the form. The application form may be submitted in person at the Division of Motor Vehicles Central Office or to any registrar's office, or by mail to the address listed on the front, upper left hand corner of the application form. The application form is available at the Department of Public Safety web site **www.dps.state.mn.us**.

ISSUANCE

Certificates & license plates are issued by the MN Department of Public Safety (DPS), Driver and Vehicle Services Division, 651-297-3377. ***Note***: This number has voice mail which will run through twice and then a caller will be connected with an individual in this section of the DPS.

There is no fee charged to individuals requesting a long-term (13-71 months) or permanent certificate (72 months). There is a $5 fee for temporary (up to six months) or short-term (7 to 12 months).

ELIGIBILITY

To be eligible for a disability parking certificate the applicant must meet one or more of the definitions of a "physically disabled person "described below. The applicant is eligible if:

A. They have a cardiac condition to the extent that functional limitations are classified in severity according to the standards set by the American Heart Association.
B. They use portable oxygen.
C. They are restricted by a respiratory disease.

D. They have lost an arm or a leg and do not have or cannot use an artificial limb.
E. *They cannot walk without the aid of: another person or device, e.g., wheelchair or cane.
F. *Walking 200 feet would be life threatening.
G. *They cannot walk 200 feet without stopping to rest.
H. *They cannot walk without a significant risk of falling.
I. *They have a specific medical condition related to pregnancy.

*Conditions E through I must specifically identify the disability.

Determination of eligibility is based on a Health Professional's signature. Persons with hidden disabilities (heart conditions, non-visible mobility impairments) should not hesitate to apply.

PRIVILEGES Persons eligible for disability parking may park at public parking meters without having to feed the meters or without regard to time limits unless otherwise posted. They may also park in non-metered passenger spaces without regard to time limits *unless* the limits are posted separately on a sign.

TICKETS Individuals who were issued a ticket even though they had a certificate or license plates should contact the police department in the city or town where it was issued.

OUT OF STATE PARKING PERMITS HONORED

Minnesota vehicles displaying disability license plates or parking certificates may also enjoy parking privileges in other states. As a result of federal law, a reciprocity agreement was made among states to recognize out-of-state disability parking permits or license plates. When planning to travel to another state, it's a good idea to inquire ahead to learn what those specific privileges are.

RESIDENTIAL AREAS For information on disability parking spaces in residential areas, contact:

Minneapolis -Traffic Engineering Section 612-673-2411

St. Paul - Public Works Department 651-266-6200
Out side of Twin City Area - City Planning Office or Public Works

DISABILITY PARKING SIGNS

Disability parking signs may be ordered from any local business that prints signs.

PAINTING ON PAVEMENT

Painting the wheelchair symbol on the pavement is not required in code and therefore is not necessary. There must be a sign posted so that it is visible from within the vehicle.

PARKING SPACES

Number of required designated parking spaces for the disabled:

TOTAL PARKING SPACES	ACCESSIBLE PARKING SPACES REQUIRED	"VAN ACCESSIBLE" SPACES REQUIRED
1 TO 25	1	1
26 TO 50	2	1
51 TO 75	3	1
76 TO 100	4	1
101 TO 150	5	1
151 TO 200	6	1
201 TO 300	7	1
301 TO 400	8	1
401 TO 500	9	2
501 TO 1000	2% OF TOTAL	1 IN EVERY 8 ACCESSIBLE SPACES
OVER 1000	20 PLUS 1 FOR EACH 100 OVER 1000	

- Each designated space must be 8' wide with an adjacent 5' wide access aisle.
- Van accessible space must have an adjacent 8' wide access aisle.
- Van accessible space must have a sign indicating "van accessible."
- Designated spaces to be on an accessible route located as near as possible to an accessible entrance.
- Each space to have a sign with the international symbol of accessibility, indicating that a permit is required and notification of a $200 maximum fine for violation.

ADA

The Americans with Disabilities Act of 1990 prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation and telecommunications. It also applies to the United Sates Congress.

To be protected by the ADA, one must have a disability or have a relationship or association with an individual with a disability. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment. The ADA does not specifically name all of the impairments that are covered. Further information on the ADA is available at:

ADA Website
www.usdoj.gov/crt/ada/adahom1.htm
Call to obtain answers to general and technical questions about the ADA and to order technical assistance materials:
1-800-514-0301 V or, 1-800-514-0383 TTY

A Guide to Disability Rights Laws
This guide includes the Statute Citations of major laws providing for disability rights.
www.usdoj.gov:80/crt/ada/cguide.htm

You can also learn more about the Americans with Disabilities Act from: Your local public library. A 10 page annotated list of 95 ADA Publications and a video-tape are available to the public in 15,000 public libraries throughout the United States. Or from:

The Regional Disability and Business Technical Assistance Center
Great Lakes ADA and IT Center
800-949-4232 V/TTY
www.adagreatlakes.org

REHABILITATION ACT

The Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs conducted by Federal agencies (sec. 501), in programs receiving Federal financial assistance (sec. 504), in Federal employment and in the employment practices of Federal contractors (sec. 503). The standards for determining employment discrimination under the Rehabilitation Act are the same as those used in Title I of the Americans with Disabilities Act.

A discrimination complaint under Title II of the ADA or Section 504 of the Rehabilitation Act of 1973 can be filed using a form available from the Department of Justice.

www.usdoj.gov

MINNESOTA HUMAN RIGHTS ACT

The Minnesota Human Rights Act, the state's comprehensive civil rights law, prohibits discrimination on many bases, such as race, sex and disability, in many areas of life. Disability discrimination is prohibited in the areas of employment, housing and real property, public accommodations, public services, education, credit services and business. Provisions protecting the rights of individuals with disabilities were first added to the Minnesota Human Rights Act in 1973. Through a series of amendments, Minnesota's law became-and-remains broader and more protective than the federal Americans with Disabilities Act, enacted in 1990. For more information on the Minnesota Human Rights Act contact:

DISABILITY ORGANIZATIONS
OF AND FOR PEOPLE WITH DISABIILTIES

MSCOD
Minnesota State Council
On Disability

Accessible Space, Inc.
Lynda Adams, Director of
Contract Administration
2550 University Ave. W. #330 N
St. Paul, MN 55114
651-645-7271 800-466-7722
Fax 651-645-0541
Newsletter: "Friends of ASI"
Email: ladams@accessiblespace.org
Web:www.accessiblespace.org

ACT (Advocating Change Together)
Kathy Sanders, Admin. Assistant
1821 University Ave. W. #306 S
St. Paul, MN 55104
651-641-0297, Fax 651-641-4053
Newsletter: "Voiceprint"
Email: act@selfadvocacy.org
Web: www.selfadvocacy.com

(National) Alliance for the Mentally Ill in MN
Sue Abderholden,
Executive Director
800 Transfer Road, #7A
St. Paul, MN 55114-1422
651-645-2948, Fax 651-645-7379
888-473-0237
Newsletter: "The Mental Health Advocate"
Email: nami-mn@nami.org
Web: www.nami.org/namimn

Alzheimer's Association,
MN- Dakotas Chapter
Mary Birchard, Executive Director
4550 W. 77th St. #200
Edina, MN 55435-5015
952-830-0512 800-232-0851
Fax 952-830-0513
Web. www.alzmndak.org

American Cancer Society
Midwest Division
Howard Heino, VP Operations
2520 Pilot Knob Road, #150
Mendota Heights, MN 55120
651-255-8100, Fax 651-255-8133
866-228-4327 V/TTY
Newsletter: "Volunteers Victories"
Web. www.cancer.org

American Council of the Blind
Enterprises and Services
James Olsen,
Chief Financial Officer
120 S. 6th St., #1005
Minneapolis, MN 55402-1839
612-332-3242 or 612-332-3244
800-866-3242, Fax 612-332-7850
Newsletter: " The Braille Forum"
Email: acbesall@ix.netcom.com
Web: www.acb.org

American Council of the Blind of MN
Ken Rodgers, President
P.O. Box 7341
Minneapolis, MN 55407
612-825-0248
Newsletter: "Minnesota Memo"

American Diabetes Association,
Minnesota Area
Jenni Hargraves, Executive Director
715 Florida Ave. S. # 307
Minneapolis, MN 55426
763-593-5333, Fax 763-593-1520
888-342-2383-MN only
Newsletter: "Action"
Email: ljohnson@diabetes.org
Web: www.diabetes.org

American Heart Association
4701 W 77th Street
Minneapolis, MN 55435
952-835-3300, Fax 952-835-5828
Newsletter:"Heart and Stroke News"
Web: www.americanheart.org

American Lung Association of Minnesota
Jerry Orr
490 Concordia Ave.
St. Paul, MN 55103-2441
651-227-8014, Fax 651-227-5459
Newsletter: "Breathe Easy"
Email: info@alamn.org
Web: www.alamn.org

Anoka-Metro Regional Treatment Center
David Hartford, Hospital Administrator
3301 7th Ave. North
Anoka, MN 55303
763-712-4000, Fax 763-712-4013
763-712-4002 TTY

ARC Minnesota
Executive Director
770 Transfer Road, #26
St. Paul, MN 55114
651-523-0823, Fax 651-523-0829
Newsletter: "Focus"
Email: mail@arcminnesota.com
Web: www.arcminnesota.com

ARRM (Association of Residential Resources in Minnesota)
Bruce Hall Nelson, Exec. Director
1185 N. Concord St. #424
St. Paul, MN 55075
651-291-1086, Fax 651-293-9389
800-551-2211
Newsletter: "Program Notes"
Web: www.arrm.org

Arthritis Foundation, Chapter Serving MN, ND & SD
Deboralh Sales Maysack, President
1902 Minnehaha Ave. West
St. Paul, MN 55104
651-644-4108, Fax 651-644-4129
800-333-1380
Newsletter: "Tipsheet"
Email: info.mn@arthritis.org
Web: www.arthritis.org

Blind, Inc. (Blindness: Learning In New Dimensions)
Shawn Mayo, Executive Director
100 East 22nd Street
Minneapolis, MN 55404-2514
612-872-0100, Fax 612-872-9358
800-597-9558
email: info@blindinc.org
Web: www.blindinc.org

Brain Injury Association of MN
Tom Gode, Executive Director
34 13th Ave. N.E., #B0001
Minneapolis, MN 55413-1005
612-378-2742, Fax 612-378-2789
800-669-6442 Newsletter: "Headlines" & "Headlines Online"
Email: info@braininjurymn.org
Web: www.braininjurymn.org

Brainerd Regional Human Services Center
Jim Holien, Site Director
11800 State Hwy 18
Brainerd, MN 56401-6250
218-828-2201, Fax 218-828-2207
Web:
www.dhs.state.mn.us/contcare/rtcl/brainerd

Camp New Hope, Inc.
Hope and Michael Roberts,
Executive Directors
53035 Lake Avenue
McGregor, MN 55760
218-426-3560 phone/Fax
Newsletter: "Camp New Hope Gazette"
Email: cnewhope@lcp2.net
Web: www.campnewhopemn.org

Camp Omega, Adults with Developmental Disabilities
Kevin Hall, Director
22750 Lind Ave.
Waterville, MN 56096
507-685-4266, 988-546-CAMP
Newsletter: "Omega World"
Web: www.campomega.org

Camphill Village Minnesota, Inc.
Bill Briggs, Administrator
15136 Celtic Drive
Sauk Centre, MN 56378
320-732-6365 Fax: 320-732-3204
Newsletter: "4 Seasons Rpt"
Email: cvmn@rea-alp.com
Web: www.camphill.org

Capable Partners, Inc.
P.O. Box 27664
Golden Valley, MN 55427-0664
763-439-1038
Web: www.capablepartners.org

(MN) Chronic Fatigue Syndrome/ Fibromyalgia Association
1885 University Ave. #25
St. Paul, MN 55104
651-644-4975, Fax:651-644-3023
Newsletter: "Info & Update"
Email: cfsamn@compaq.net
Web: www.cfsmn.org

Client Assistance Project (CAP)
MN Disability Law Center
430-1st Ave. North, #300
Minneapolis, MN 55401-1780
612-332-1441, Fax:612-334-5755
612-332-4668-TTY
800-292-4150 V/TTY
Newsletter: "MN Disability Law Project"

CLIMB Theater Company
Peg Wetli, Executive Director
6415 Carmen Ave. East
Inver Grove Heights, MN 55076
651-453-9275, Fax:651-453-9274
800-767-9660,
Email: mail@climb.org
Web: www.climb.org

Closing the Gap
Bud and Delores Hagen
526 Main St., P.O. Box 68
Henderson, MN 56044
507-248-3294, Fax 507-248-3810
Web: www.closingthegap.com

Communication Center
State Services for the Blind
David Andrews, Director
2200 University Ave. W. #240
St. Paul, MN 55114-1840
651-642-0513 or 651-6342-0500
651-642-0506 TTY,
800-652-9000, Fax 651-649-5927
Newsletter: "Newslines"

Communication Service Center for the Deaf, (CSD) of MN
2055 Rice Street
St. Paul, MN 55113
651-297-6700 V/TTY
Fax: 651-297-6766
877-456-7589 V/TTY
Interpreter Referral
651-224-6548
877-456-7589 V/TTY
Web: www.c-s-d.org

Confidence Learning Center
(Camp Confidence)
Jeff Olson, Executive Director
1620 Mary Fawcett Memorial Dr.
Brainerd, MN 56401-7614
218-828-2344, Fax:218-828-2618
Newsletter: "The State of Confidence"
Email: info@campconfidence.com
Web: www.campconfidence.com

Courage Center
3915 Golden Valley Road
Golden Valley, MN 55422
763-588-0811, Fax:763-520-0392
763-520-0245 TTY
Email: jenim@courage.org
Web: www.courage.org

Cystic Fibrosis Foundation
Jill Evenocheck, Exec. Director
1611 W. County Road B, #221
St. Paul, MN 55113
651-631-3290, Fax:651-631-3296
Email: minn@cff.org
Web: www.cff.org

Deaf Blind Services MN, Inc.
Steve Fischer, Executive Director
726 2nd St. N.E.
Minneapolis, MN 55413
612-362-8454, Fax:612-362-8437
612-362-8422 TTY
Email: info@dbsm.org
Web www.dbsm.org

Deaf and Hard of Hearing Services Division, Department of Human Services
Bruce Hodek, Director
444 Lafayette Road
St. Paul, MN 55155-3814
651-296-3980 651-297-1506 TTY
Fax: 651-891-7155
Web: www.dhhsd.org

Department of Human Rights
Velma Korbel, Commissioner
190 E. 5th St., #700
St. Paul, MN 55101
651-296-5663 651-296-1283 TTY
800-657-3704 Fax 651-296-9064
Web:
www.humanrights.state.mn.us

Dept. of Public Safety, Disability Plates and Certificates
445 Minnesota Street, #164
St. Paul, MN 55101
651-297-3377 651-297-2100 TTY
Email: motor.vehicles@state.mn.us
Web: www.dps.state.mn.us

Department of Commerce
Glenn Wilson, Commissioner
85 E. 7th Place East, #600
St. Paul, MN 55101-3165
651-296-4026 800-657-3599
Web. www.commerce.state.mn.us
Telecommunication Access MN (TAM), MN Relay
MN Dept. of Commerce
Rochelle Garrow,
Program Administrator
651-297-8941 Fax:651-284-4107
Rochelle.garrow@state.mn.us

Disability Services Division,
MN Dept. of Human Services
Shirley York, Director
2284 Highcrest Road
Roseville, MN 55113
651-582-1998 V/TTY
Fax: 651-582-1808
800-747-5484

Disability Services Division
MN Dept. of Human Services
Continuing Care for Persons with Disabilities
Linda Wolford, Policy Consultant
1-877-627-3848 -Speech-to-Speech
1-800-627-3529-TTY
2284 Highcrest Road
Roseville, MN 55113

Disability Services,
University of MN
Bobbi Cordano, Director
McNamara Alumni Center
200 Oak St. S.E., #180
Minneapolis, MN 55455
612-626-1333 V/TTY
Fax: 612-626-9654
Web: www.ds.umn.edu

Disabled American Veterans,
MN Department
Dean Ascheman, Adjutant
Veterans Service Building, 3rd Floor
St. Paul, MN 55155
651-291-1212, Fax:651-291-0115
Newsletter: "DAV News"
Email: davets@qwest.net
Web: www.davmn.org

Emotions Anonymous, International Service Center
Karen Mead, Executive Director
Box 4245-2233 University Ave. West, #402
St. Paul, MN 55104-0245
651-647-9712, Fax 651-647-1593
Email:
info@EmotionsAnonymous.org

Epilepsy Foundation of MN
John Thompson, Information and Referral Coordinator
1600 University Ave., #205
St. Paul, MN 55104
651-287-2303 651-287-2300 TTY
Fax 651-287-2325 800-779-0777
Email: info.efmn@mr.net
Web: www.efmn.org

Fergus Falls Regional Treatment Center
Bill Dorhoff, Site Director
1400 N. Union Ave.
Fergus Falls, MN 56537-1200
218-739-7200 218-739-7455 TTY
Fax: 218-739-7243
Eldon Dietel, ADA Coordinator
Email: eldon.dietel@state.mn.us
Web: www.dhs.state.mn.us

Flying Wheels Travel
Barbara Jacobson, Manager
143 W. Bridge Street
Owatonna, MN 55060
507-451-5005 Fax: 507-451-1685
800-535-6790
Newsletter: "Wheelie News"
Email: thq@11.net
Web: www.flyingwheelstravel.com

Friendship Ventures
Georgann Rumsey,
President & CEO
10509 108th St. N.W.
Annandale,MN 55302
952-852-0101 Fax:952-852-0123
Newsletter: "Friendship News"
Email: fv@friendshipventures.org
Web: www.friendshipventures.org

Gillette Children's Hospital
Specialty Healthcare
Cerebral Palsy Program
Candace Vegter, Program Manager
200 University Ave.
St. Paul, MN 55101
651-290-8712 Fax: 651-229-3833

Gillette Children's Hospital
Epilepsy Program for Children (MNCEP)
Neurology Clinic
200 East University Ave.
St. Paul, MN 55101
651-229-3870 Fax: 651-229-1718

Hazelden Fellowship Club
Brenda Iliff, Executive Director
680 Stewart Ave.
St. Paul, MN 55102
763-509-3900 Fax 651-227-1599
800-257-7810, ext. 3900
Web: www.hazelden.org

HDS Specialty Vehicles
16290 Kenrick Loop
Lakeville, MN 55044-8495
952-435-8889 800-826-6176
Email: HDSmn@excite.com
Web: www.hdsmn.com

Hearing and Service Dogs of MN
Alan M. Peters, Executive Director
2537 25th Ave. South
Minneapolis, MN 55406
612-729-5986
Fax/TTY 612-729-5914
Newsletter: "Tails from Minnesota"
Web: www.hsdm.org

Helping Paws of Minnesota, Inc.
P.O. Box 634
Hopkins, MN 55343
952-988-9359 Fax: 952-988-9296
Newsletter: "Pawprint"
Email: helpingpaws@ens.net
Web: www.helpingpaws.org

Hemophilia Foundation of MN/Dakotas
James Paist, Executive Director
750 S. Plaza Drive, #207
Mendota Heights, MN 55120
651-406-8655 Fax: 651-406-8656
Newsletter: "Veinline"
Email: hemophiliafound@visi,com
Web: www.hfmd.org

Institute on Community Integration (UAP), University of MN
David R. Johnson, PhD, Director
102 Pattee Hall
150 Pillsbury Drive S. E.
Minneapolis, MN 55455
612-624-6300 Fax: 612-624-9344
Newsletter: "Impact"
Web: www.ici.umn.edu

Learning Disabilities Association
Kitty Christiansen,
Executive Director
4301 Highway 7,
160 Diamond Hill Center.
Minneapolis, MN 55416
952-922-8374 Fax: 952-922-8102
Newsletter: "Learning Times"
Web: www.ldalearningcenter.com

Legal Advocate for the Blind
Casey Streich, Contact Person
429 Oliver Ave. South
Minneapolis, Mn 55405
612-377-1788

Legal Aid Society of Minneapolis
Northside Office,
Urban League Building
2100 Plymouth Ave. North #14
Minneapolis, MN 55401
612-588-2099 Fax: 612-436-5412
Newsletter: "MN Disability Law Report"

Leukemia and Lymphoma Society
Murray Schmidt, Executive Director
5217 Wayzata Blvd. #221
St. Louis Park, MN 55416
952-545-3309 Fax:952-545-5926
888-220-4440
Information Resource Center,
800-955-4572

Lupus Foundation of Minnesota
Judi Deming, President
The Atrium, # 135
2626 East 82nd Street
Bloomington, MN 55425
952-746-5151 800-645-1131
Newsletter: "Lupus News"
Web: www.lupusmn.org

Lutheran Braille Evangelism Association
Rev. Dennis A. Hawkinson,
Executive Director
1740 Eugene Street
White Bear Lake, MN 55110-3312
651-426-0469
Newsletter: "Braille Evangelism Bulletin"
Email: lbea@qwest.net
Web: lbea.org

Mental Health Association of MN
Sandra Meicher, Executive Director
2021 East Hennepin Ave., #412
Minneapolis, MN 55413-2726
612-331-6840 Fax: 612-331-1630
800-862-1799
Newsletter: "Focus"
Web: www.mentalhealthmn.org

Minnesota Administrators for Special Education (MASE)
Don Schuld, President
1884 Como Ave.
St. Paul, MN 55108-2715
651-645-6272 Fax: 651-645-7518
Newsletter: "Impact"
Web: www.mnase.org

Minnesota Aids Project
Lorraine Teel, Executive Director
1400 Park Ave.
Minneapolis, MN 55404-1550
612-341-2060 V/TTY
888-820-2437
612-373-2437-Metro Hotline
Fax: 612-341-4057
Web: www.mnaidsproject.org

MINCEP Epilepsy Care
Robert J. Gummit, M.D., Director
5775 Wayzata Blvd.
Minneapolis, MN 55416
952-525-4500 Fax: 952-525-1560
Email: hello@mincep.com
Web: www.mincep.com

(MN) Tourette Syndrome Association
Julie Zabloski, Executive Director
10249 Yellow Circle Drive, #103
Minnetonka, MN 55433
952-918-0350
Email: director@tsa-mn.org
Web: www.tsa-mn.org

Minnesota Children with Special Health Needs (MCSHN)
MN Department of Health
John Hurley, Section Manager
85 East 7th Place, #400
St. Paul, MN 55164-0882
612-215-8956 Fax: 651-281-9988
800-728-5420
Web: www.health.state.mn.us

Minnesota Commission Serving Deaf & Hard of Hearing People
Mary Hartnet, Executive director
444 Lafayette Road
St. Paul, MN 55155-3814
651-297-7305 V/TTY
Fax: 651-297-7155
Newsletter: "North Star"

MN DACA (MN Developmental Achievement Association)
Gerald Mueller, Executive Director
1821 University Ave., #292-S
St. Paul, MN 55104
651-647-9200, Fax:651-647-9353
Newsletter: "MN DACA News & Review"
Web: www.mndaca.org

MN Disability Law Project
Pamela Hoopes, Legal Director
430 First Ave. North, # 300
Minneapolis, MN 55401-1780
612-332-1441 Fax: 612-334-5755
Intake: 612-334-5970
612-332-4668 TTY 800-292-4150
Newsletter: "MDLC Notes"
Email: phoopes@midmnlegal.org
Web: www.mndlc.org

MELD
219 N. 2nd St., #200
Minneapolis, MN 55401
612-332-7563 Fax: 612-344-1959
Email: info@meld.org
Web: www.meld.org

MN Extended Treatment Options
Mike Maus, Administrator
1235 Highway 293
Cambridge, MN 55008
761-689-7224, Fax:763-689-7255
Newsletter: "Weekly Bulletin"
Email: mike.maus@state.mn.us
Web: www.dhs.state.mn.us

MN Governor's Council on
Developmental Disabilities
Colleen Wieck, PhD,
Executive Director
658 Cedar St.,
370 Centennial Bldg.
St. Paul, MN 55155
651-296-4018, Fax 651-297-7200
MN Relay Service 800-627-3529
877-348-0505
Email: admin.dd@state.mn.us
Web: www.mnddc.org

Minnesota Housing Finance Agency
(MHFA)
Timothy E. Marx, Commissioner
400 Sibley Street, #300
St. Paul, MN 55101
651-296-5738 Fax: 651-296-8139
651-297-2361 TTY
Email: mhfa@state.mn.us
Web: www.mhfa.state.mn.us

MN Library for the Blind and
Physically Handicapped (MLBPH)
Catherine Durivage,
Library Program Director
388 S.E. 6th Ave.
Faribault, MN 55021-6340
507-333-4828 Fax: 507-333-4832
800-722-0550
Newsletter: "MN Library for the
Blind and Physically Handicapped"
Email: mn.lbph@state.mn.us
Web: www.education.state.mn.us

Minnesota Resource Center
Kim Feller, Director
1900 Chicago Ave.
Minneapolis, MN 55404
612-752-8000 Fax:612-752-8001
612-752-8019 TTY
Newsletter: "Resource Inc."
Email: kfeller@resource-mn.org
Web: www.resource-mn.org
*(Employment Action Center,
Recovery Resource Center,
Spectrum Community Mental
Health)

Minnesota State Operated
Community Services (SOCS)
444 Lafayette
St. Paul, MN 55155-3818
651-582-1858 Fax: 651-582-1863

Minnesota Speech-Language-
Hearing Association
Frances Laven, Association
Manager
P.O. Box 26115
Minneapolis, MN 55426
952-920-0787 Fax: 952-920-6098
Newsletter: "Newsletter"
Web: www.msha.net

Minnesota State Academy for the
Blind
Linda Mitchell, Superintendent
400 S.E. 6th Ave. Box 68
Faribault, MN 55021
507-333-4800, Ext. 4801
800-657-3634 Fax: 507-333-4825
Email: esveen@msab.state.mn.us
Web: www.msab.state.mn.us

Minnesota State Academy for the
Deaf
Linda Mitchell, Superintendent
615 Olaf Hanson Drive, Box 308
Faribault, MN 55021-0308
507-332-5400 Fax: 507-332-5404
800-657-3996 V/TTY
Newsletter: "Companion"
Email: msad@msad.state.mn.us
Web: www.msad.state.mn.us

Minnesota State Bar Association
Volunteer Attorney Program
600 Nicollet Mall, #380
Minneapolis, MN 55402-1021
612-333-1183 Fax: 612-333-4927
800-882-6722
www.mnbar.org

MN State Council on Disability
Joan Willshire, Executive Director
121 E. 7th Place, #107
St. Paul, MN 55101-2114
651-296-6785 V/TTY
800-945-8913 V/TTY
Fax: 651-296-5935
Email:
council.disability@state.mn.us
Web: www.disability.state.mn.us

Muscular Dystrophy Association
Amyotrophic Lateral Sclerosis Div.
Erin Ouren
7401 Metro Blvd., #325
Edina, MN 55439
952-832-5517 V/TTY
Fax: 952-831-7131
www.mdausa.org

National Ataxia Foundation
Mike Parent, Executive Director
2600 Fernbrook Lane, #119
Plymouth, MN 55447
763-553-0020 Fax 763-553-0167
Web: www.ataxia.org

National Federation of the Blind-MN
Joyce Scanlan, President
100 East 22nd Street
Minneapolis, MN 55404-2514
612-872-9363 Fax 612-872-9356
Newsletter: "Minnesota Bulletin"
Email: joyce.scanlan@earthlink.net

National Handicapped Housing Institute
1050 Thorndale Ave.
New Brighton, MN 55112
651-639-9799 Fax 651-639-9699

National Kidney Foundation of MN, Inc.
Peggy McGrew, Executive Director
1660 Hwy.100 South, #530
St. Louis Park, MN 55416
952-544-7300 Fax: 952-544-2320
800-866-4499
Newsletter: "Nat'l Kidney Foundation"
Web: nkfmn.org

National Multiple Sclerosis Society, Minnesota Chapter
Maureen Reeder, President
200 12th Ave. South
Minneapolis, MN 55415
612-335-7900
Fax: 612-335-7997
800-582-5296 V/TTY
Newsletter: "MS Connection"
Email: info@mscociety.org
Web: www.mnms.org

Neurofibromatosis, Inc. MN
P.O. Box 18246
Minneapolis, MN 55418
612-362-4413
Newsletter: "NF Inc"
Email: JohnE@cipmn.org
Web: www.nfinc.org

Ombudsman Office for Mental Health and Mental Retardation
Paul Doyle, Director of Policy and Administration
121 East 7th Place, #420
St. Paul, MN 55101-2114
651-296-3848 Fax: 651-296-1021
800-657-3506
Email: ombudsman.mhmr@state.mn.us
Web: www.ombudmhmr.state.mn.us

Opportunity Partners, Inc.
Paul Jaeger, Vice President, Vocational Programs
5500 Opportunity Court
Minnetonka, MN 55343
952-938-5511 Fax: 952-830-4279
952-930-4293 TTY
Newsletter: "Opportunities"
Email pjaeger@opportunities.org
Web: www.opportunities.org

PACER Center, Inc.
(Parent Advocacy Center on Educational Rights)
Paula F. Goldberg, Executive Director
8161 Normandale Blvd.
Minneapolis, Mn 55437-1044
952-838-9000 Fax: 952-838-0199
952-838-0190 TTY 800-537-2237
Email: pacer@pacer.org
Web: www.pacer.org

People Incorporated
Mary Kay McJilton,
Director of Operations
317 York Ave.
St. Paul, MN 55101
651-774-0011 Fax: 651-774-0606
651-774-6535 TTY
Newsletter: "In Touch"
Web: www.peopleincorporated.org

People Inc-Array East
Herman Fetchman, Director
700 East 8th Street
St. Paul, MN 55106
651-644-2232 Fax: 651-771-8105
651-917-0478 /TTY
Web: www.peopleincorporated.org

Regions Hospital
Neurology Department
640 Jackson St.
St. Paul, MN 55101
651-254-3456

Rehabilitation Services
Administration Offices
1st National Bank Bldg. #E200
332 Minnesota Street
St. Paul, MN 55101-1351
651-296-5616 Fax:651-297-5159
651-296-3900 TTY 800-328-9095
Web: www.mnworkforcecenter.org

Resource Inc.,
Minneapolis Resource Center
Bob Berlute, President
1900 Chicago Ave. South
Minneapolis, MN 55404
612-752-8002 Fax: 612-752-8001
612-752-8019 TTY
Newsletter: "The Resource"
Web: www.resource-mn.org

Senior LinkAge Line
800-333-2433

Senior Resources
Kathy Mosavat
2021 East Hennepin Ave., #200
Minneapolis, MN 55413-2733
612-331-4063 Fax: 612-331-6772

Shriners Hospital for Children
Twin Cities Shriners Hospital
Lawrence E. Johnson, Admin.
2025 East River Parkway
Minneapolis, MN 55414-3696
612-596-6100 Fax:612-339-7634
888-293-2832
Newsletter:"Twin Cities Quarterly"
www.shrinershq.org

Sister Kenney Rehabilitation Inst.
Abbott Northwestern Hospital
Roberta Dressen, Vice President
800 East 28th St. at Chicago
Minneapolis, MN 55407
612-863-4466 Fax: 612-863-5667
Web:
www.sisterkennyinstitute.com

Special Olympics Minnesota
Linda Ewing, President
400 4th Ave. South, #915
Minneapolis, MN 55415-1423
612-333-0999, 800-783-7732
Fax: 612-333-8782
Newsletter: "Forerunner"
Email: gvanselow@somn.org
Web: www.somn.org

Spina Bifida Association of MN
Julie Abbott, President
Kelly Socha, Vice President
Jim Thayer, Executive Director
P.O. Box 29323
Brooklyn Center, MN 55429
Hotline: 651-222-6395
Newsletter: "Spina-Bifida: Hope for the Future/News for Today"
Web: sbamn.com

Spinal Cord Society-
Twin Cities Chapter
Mike Janssen, Chapter Head
2785 104th Court East
Inver Grove Heights, MN 55077
651-455-3137 Fax: 651-455-3137
Newsletter: "SCS Newsletter"
Email: eweturnrch@comcast.net
Web: users.aol.com/scsweb

State Services for the Blind and
Chuk Hamilton, Director
2200 University Ave. West, # 240
St. Paul, MN 55114-1840
651-642-0500 Fax: 651-649-5927
651-642-0506 TTY 800-652-9000
Web: www.mnssb.org

Struthers Parkinson's Center
Rpse Wichmann, Manager
6701 Country Club Drive
Golden Valley, MN 55427
952-993-5495 Fax: 952-993-2250
888-993-5495
Newsletter: "Satellite"
Email: hagersr@hsmnet.com
Web:
www.parknicollet.com/methodist/parkinsons

United Blind of Minnesota, Inc.
Kay L. Briden, President
3200 West 88th Street
Bloomington, MN 55431
952-922-0871
763-391-3699-News Line

United Cerebral Palsy of MN
Jo Ann Erbes, Executive Director
1821 University Ave. # 219 S
St. Paul, MN 55104-2892
651-646-7588 Fax: 651-646-3045
800-328-4827, Ext. 1437
Newsletter: UCP Advocate
Email: ucpmn@cpinternet.com
Web: www.ucp.org (national)

Very Special Arts Minnesota
Craig Dunn, Executive Director
528 Hennepin Ave., #305
Minneapolis, MN 55403
612-332-3888 V/TTY
800-801-3883 V/TTY
Fax: 612-305-0132
Newsletter: "Arts Access"
Email: vsarts@bcmn.com
Web: http://mn.vsarts.org

Veterans Administration Regional-
Office and Insurance Center
Voc. Rehab. and Employment
One Federal Drive-Bldg. Ft. Snelling
St. Paul, MN 55111-4050
800-827-1000

Vinland Center
Carol Jackson, Executive Director
P.O. Box 308
Loretto, MN 55357
763-479-3555 V/TTY
Fax: 763-479-2605
Email:
vinlandcenter@vinlandcenter.org
Web: www.vinlandcenter.org

Volunteer Braille and Large Print Services
4139 Regent Ave. North
Robbinsdale, MN 5422
763-544-2880

Wilderness Inquiry, Inc.
Mike Miller, Outreach Assistant
808 14th Ave. South East
Minneapolis, MN 55414-1516
612-676-9400 Fax: 612-676-9401
612-676-9475 TTY
800-728-0719
Email: info@wildernessinquiry.org
Web: www.wildernessinquiry.org

NATIONAL RESOURCE ORGANIZATIONS

National Council on Disability

The National Council on Disability (NCD) is an independent federal agency making recommendations to the President and Congress to enhance the quality of life for all Americans with disabilities and their families. NCD is composed of 15 members appointed by the President and confirmed by the U.S. Senate. In its 1986 report Toward Independence, NCD first proposed that Congress should enact a civil rights law for people with disabilities. In 1990, the *Americans with Disabilities Act* was signed into law.

Contact Information
1331 F Street, NW, Suite 850
Washington, DC 20004
202-272-2004 Voice, 202-272-2074 TTY, 202-272-2022 Fax

National Organization on Disability

The mission of the National Organization on Disability (N.O.D.) is to expand the participation and contribution of America' s 54 million men, women and children with disabilities in all aspects of life. By raising disability awareness through programs and information, together we can work toward "closing the participation gaps".

Contact Information:
910 16th Street N.W., Suite 600
Washington, DC 20006
202-293-5960, 202-293-5968 TTY, 202-293-7999 Fax
Email: **ability@nod.org**

Office of Disability Employment Policy, U.S. Department of Labor

Contact Information
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210
1-800-633-7365 Voice, 1-877-889-5627 TTY

Disability Linkage Line™

(866) 333-2466

Disability Linkage Line™: Creating Easier Access to Services

The Minnesota Department of Human Services launched a new information, referral and assistance service for people with disabilities called Disability Linkage Line (DLL). Now, those needing disability related information and referrals can get connected to community services and supports by calling one, statewide number: **1-866-333-2466.**

Why was Disability Linkage™ Line Created?

Disability Linkage Line evolved out of a planning effort the Disability Services Division (DSD) held in 2001. DSD asked stakeholders, providers and consumers what changes were needed to help support people with disabilities in living successful, self-determined lifestyles in the community of their choice. The re-sounding feedback was a better information, referral and assistance system was needed to assure people knew their options and made informed decisions.

How Does Disability Linkage™ Line Operate?

DLL operates as part of an interconnected information and referral system that includes **Senior LinkAge Line®,** the statewide on-line database **MinnesotaHelp.info,** and other community information and service providers. This interconnected system is dedicated to working together to assure people receive consistent, quality information no matter where they turn for help.

To reach Disability Linkage Line, people with disabilities, chronic illness and their representatives can call **1-866-333-2466** during business hours. The caller will be provided in-depth information about community options and if necessary assistance in accessing community services. After initial referrals are given, callers will be offered follow-up to make sure their needs were met and that they successfully connect to the service of their choice. People who prefer to look for the resources on-line can go to www.MinnesotaHelp.info.

Who Provides Disability Linkage™ Line Services?

- the **Metropolitan Center for Independent Living**, receives calls from the metro area and northern Minnesota, and
- the **Southeastern Minnesota Center for Independent Living**, receives calls from central and southern Minnesota.

Disability Linkage Line™

Disability Linkage Line Statewide Coordinators

Description	Contact
Looking for community resources	**Disability Linkage Line 1-866-333-2466** www.MinnesotaHelp.info
Reporting feedback and suggestions for improving the Disability Linkage Line services	**Lesli Kerkhoff** DHS Disability Linkage Line Project Manager Phone: 651-634-2281 Lesli.Kerkhoff@state.mn.us
Counties Served	**Disability Linkage Line Coordinator**
METRO REGION Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, and Washington	**Mike Chevrette** Metro Coordinator Metropolitan Center for Independent Living 1600 University Avenue, Suite 16 St. Paul, MN 55104-3825 Phone: 651-603-2005 Fax: 651-603-2006 Email: mikec@mcil-mn.org
NORTHERN REGION Kanabec, Mille Lacs, Pine, Carlton, Aitkin, Itasca, St. Louis, Lake, Cook, Koochiching, Lake of the Woods, Beltrami, Clearwater, Hubbard, Mahnomen, Norman, Red Lake, Pennington, Polk, Marshall, Roseau, Kittson, Cass, Crow Wing, Wadean, Todd, and Morrison	**Sandra J. Parsons, PhD** Northern Coordinator Metropolitan Center for Independent Living 1819 Bemidji Avenue Bemidji, Mn 56601 Phone: 218-444-2171 Fax: 218-444-2171 Email: sandrap@mcil-mn.org
SOUTHERN REGION Blue Earth, Brown, Cottonwood, Dodge, Faribault, Fillmore, Freeborn, Goodhue, Houston, Jackson, Le Sueur, Lincoln, Lyon, McLeod, Martin, Mower, Murray, Nicollet, Nobles, Olmsted, Pipestone, Redwood, Renville, Rice, Rock, Sibley, Steele, Wabasha, Waseca, Watonwan, and Winona	**Margie Wherritt, CIRS** Lead Coordinator Southeastern Minnesota Center for Independent Living 2720 North Broadway Rochester, MN 55906 Phone: 507-285-3916 Fax: 507-288-8070 E-Mail: margiew@semcil.org
CENTRAL REGION Benton, Becker, Big Stone, Chippewa, Clay, Douglas, Grant, Kandiyohi, Lac Qui Parle, Meeker, Otter Tail, Pope, Sherburne, Stearns, Stevens, Swift, Traverse, Wilkin, Wright and Yellow Medicine	**Heather Weinhandl** Central Coordinator Southeastern Minnesota Center for Independent Living 700 Cedar, Suite 233 Alexandria, MN 56308-1795 Phone: 320-762-8495 Fax: E-Mail: heatherw@semcil.org

MinnesotaHelp.info

Minnesotahelp.info is the new statewide comprehensive database of local community resources for consumers, caregivers and service providers. The web site, created in a partnership between the Minnesota Board on Aging, the Department of Human Services, and other community partners provides access to information 24 hours a day, 7 days a week.

Feature of the web site include:

6 Steps: You can search for resources: by zip, city and state; by topic; by keyword; or by provider name. If you're not sure where to start, you can click on the Want Suggestions? Box on Step 2 for a list of the types of programs that match your situation.

Sign In & Home Page: handy tools to store programs and web sites you find helpful or interesting (on your Resource List) and to communicate anonymously with providers who will receive and respond to online communication. Replies come to your private Mailbox.

Tips: a bank of helpful information about a wide variety of topics designed to help you make more informed choices about services.

Print or Save: a way to print your search results or save them to your Resource List.

Download printable directories: a way to receive pre-formatted mini-directories for some of the topic areas in the database, e.g. Adoption and Foster Care.

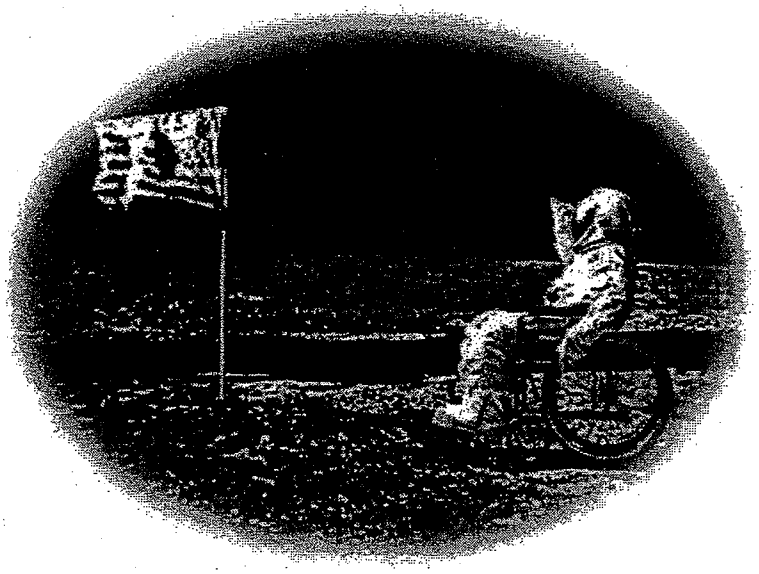
Email A Page: a quick way to send your search results to yourself or someone else via e-mail.

FAQs: a way to locate an answer to your questions by searching our database or by submitting a question to an online representative.

Consumer Reviews: helpful tips from people who have used a community resource and a way for you to post your own reviews and tips.

For Service Providers: a series of online tools that allow service providers to update their information in the database; to read and respond to email from the public; and to see how many people saved their program on their Program List. Local Information and Referral professionals check updated information for accuracy before uploading it to the web.

Features	Minnesotahelp.info
Designed by users	Developed with multiple user groups including 600+ counties, area agencies, not for profit groups serving different ages. Interface and vendor selection involved representatives from multiple groups including caregivers and consumers, as well.
Multiple Partners From Many types of organizations	While the project management lead is The Minnesota Board on Aging, numerous not-for profit organizations and for profit organizations, counties and divisions within DHS representing all ages and abilities/services are project partners (provide funding and support) and very much involved in design and approach. It is a legislatively mandated initiative.
Usability	The interface and its associated data manager and client tracking systems have gone and continue to go through usability testing, modification, and enhancement based on user needs. The system has gone through two iterations of rigorous formal acceptance testing utilize the expertise of software acceptance testing professionals.
Available in Multiple Formats	It will be available in a downloadable PDA version by February 2004 (at request of county workers). Project managers are working with multiple user groups to customize and design the various interfaces. Phase IV (completed January 2003) included an online interface for consumers. Phase V (2004 release) includes professional user interface with screening tools that utilize data sharing technology to integrate screening information into MMIS (Medicaid billing system used by DHS and counties) for billing purposes.
Usage fees and Ownership of Data	All data is public domain and distributed for free to all users. Consumer and professional screening tools will also be made available for free.
Search Results	Sortable by service features (Will this housing entity take my dog? How close is to a bus stop? What payor sources does it take – for profit, public, other?). Future customizations include the ability to sort by whether entity is an official contractor of the county.
Tracking Vacancies in Services (Service Openings)	Mandated by legislature and to be rolled out as part of Provider Annex. Information is key to the ability of hospital discharge planners, case managers and other long-term care consultants to do their work.
Interactive Online Provider Updates of Data	System allows complete interactive updates of service and availability. Provider Annex (secure provider interface with data integrity review) being piloted this fall with metro area caregiver groups with plan to full roll out in January.



People With and Without Disabilities: Interacting & Communicating

Equal Opportunity Programs Office
Goddard Space Flight Center
National Aeronautics and Space Administration

March 2004

For the latest version of this booklet, please go to our Web Site at:
http://eeo.gsfc.nasa.gov/disability/publications.html

NASA

GSFC

People With and Without Disabilities: Interacting & Communicating

This publication was prepared for all Goddard employees, especially those who have supervisors, managers, employees, or co-workers with disabilities. It is intended to provide general information and suggested behaviors that will increase the efficacy of interaction and communication.

This publication will be updated regularly. For the latest version of this document, including additional features, please go to the Publications Web page of the Program for People with Disabilities, Equal Opportunity Programs Office, Goddard Space Flight Center, National Aeronautics and Space Administration.

You can find this booklet at: http://eeo.gsfc.nasa.gov/disability/publications.html

This publication is available in an alternate format upon request.

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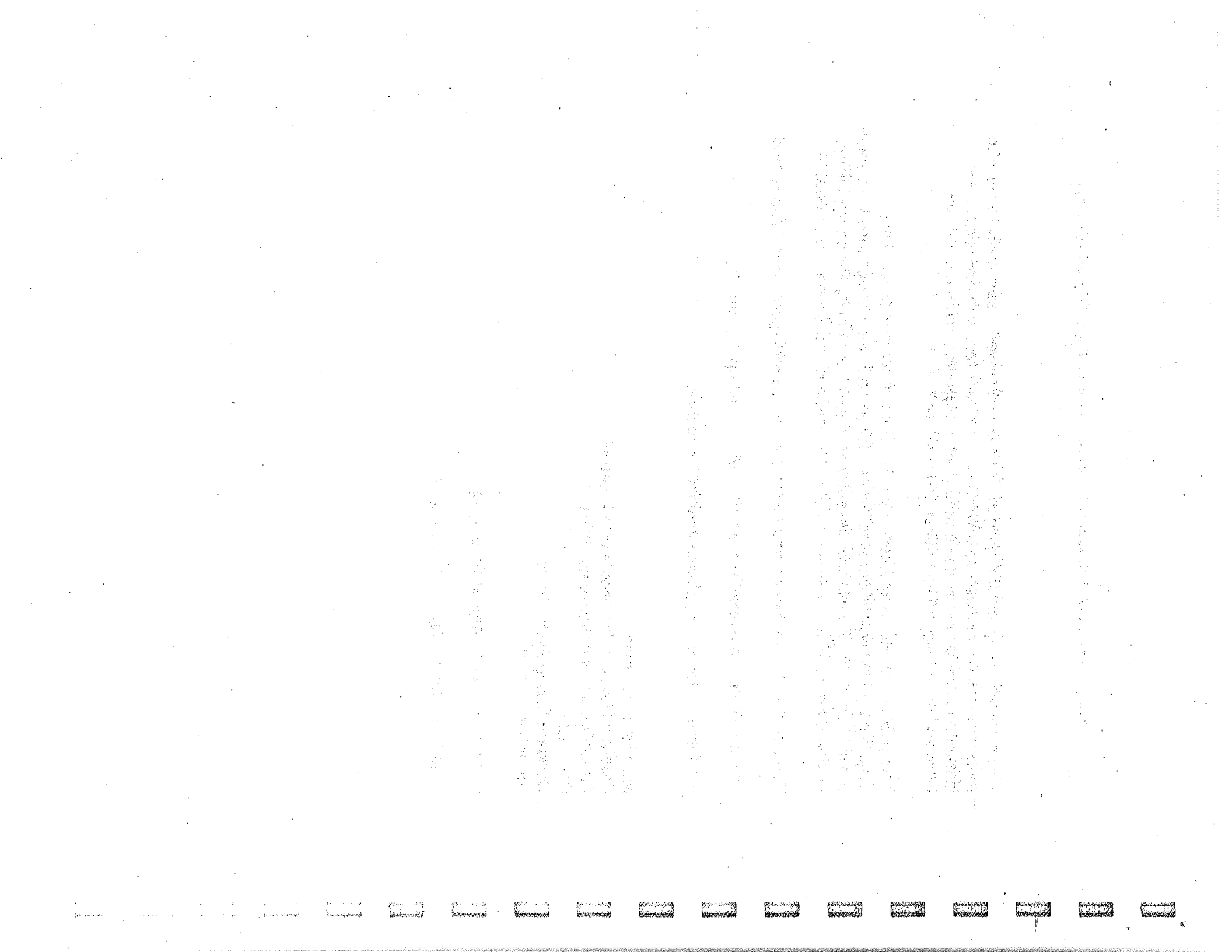


People With and Without Disabilities: Interacting & Communicating

INTRODUCTION

NASA's Goddard Space Flight Center is dedicated to the principle of inclusion for people with disabilities. We have made great strides in making our physical environment convenient for all people. In recent years, Goddard has been proactive in recruiting people with disabilities as interns, and as participants in our cooperative education program, in addition to other student "pipelines." As always, we continue to recruit and hire individuals with disabilities into our permanent work force.

We recognize, however, that we need to do more than merely provide an accessible campus and invite people in. While there are legislative requirements and standards to guarantee physical access and to remove programmatic barriers, we have an additional goal. We strive to diminish attitudinal and communication barriers that are less obvious than physical barriers, but just as critical to ensure success for employees with disabilities.

This publication is written to suggest ways to promote effective communication between people with and without disabilities. In general, there is nothing extraordinary about such communication; however, using the suggested behaviors could bridge some of the perceived and real distinctions between co-workers. This booklet is not intended to address reasonable accommodation, unless an accommodation would promote more effective communication and interaction.

People with disabilities are just people who may happen to have difficulty with basic life activities, such as walking, moving, talking, learning, breathing, seeing, or hearing. It is important to understand, though, that not all conditions, illnesses, or diseases rise to the level of a disability as defined by law.

Some of the biggest barriers faced, and the hardest to remove, are stereotypical thinking about, and erroneous images of, people with disabilities, often resulting in feelings of pity, fear, paternalism, or disdain. People with disabilities are often erroneously perceived as helpless, confined, sick, needy, of limited intelligence or capacity, or as victims.

There is no particular personality type for people with disabilities in general, nor for individuals with the same disability. Furthermore, each person has his or her unique strengths and weaknesses, likes and dislikes. Therefore, it is important to remember that the suggestions in this booklet are designed to facilitate the interactions, but they will not automatically improve the quality of relationships, among co-workers with and without disabilities. Once the communication barriers are diminished, it is up to the individuals involved to create their own mutually acceptable relationship. It is important to note also that what is

appropriate for one person might not be appropriate for another person, even if the two people have the same disability. So, when in doubt, ask your colleague what he or she prefers.

There are some people who, because of fear or discomfort, will avoid interacting with people with disabilities. Other people simply do not know what appropriate behavior is when around a person with a disability. Learning that people with disabilities are fundamentally no different from people without disabilities helps reduce fear and avoidance. People with disabilities, like all other large groups of people, represent a full range of personalities. Put simply, some are nice, some are not; some are easy to work with as colleagues, some are not; some you would like as friends, some you would not.

This booklet is arranged into broad disability groups. It does not attempt to discuss every disability or condition, only those where specific behaviors might be preferred when interacting and communicating.

Within each segment, there are two sections. "General Information" provides an introduction and basic overview of the disability. "Suggested Behaviors" provides a variety of options that will be appropriate in most situations.

Finally, it is important to recognize that there are many people with hidden disabilities or conditions which may not be immediately apparent. These include, but are not limited to, alcohol or other addictions, allergies, asthma, arthritis, cancer, chronic fatigue, chronic pain, diabetes, environmental illness, fibromyalgia, lung disease, kidney failure, hemophilia, hypertension, fragrance sensitivity, as well as the early stages of Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis, Parkinson's Disease, heart disease, and other conditions or disabilities.

People are very often affected by these hidden disabilities and conditions in ways that are less obvious, but no less severe than visible disabilities. Though there are usually no special communication needs, it should be noted that they are, nonetheless, bona fide disabilities. As such, they may require reasonable accommodations but are not included in this booklet, which will focus only on interaction and communication.

FOR ALL PEOPLE WITH DISABILITIES

GENERAL INFORMATION

A person with a disability does not necessarily need help. Most people with disabilities try to be as independent as possible and will ask for assistance only if they need it. However, if you see a situation in where you think you might be of some assistance, ask, but do not insist that the person accept your aid.

If your offer for assistance is accepted or requested, ask how you can best be of help, and then try to do it with minimum attention drawn to the person with a disability, yourself, or your activities. Don't be embarrassed to admit that you don't know what to do or how to help. Simply ask the person for guidance, and he or she will instruct you.

SUGGESTED BEHAVIORS

When talking with a person with a disability, speak and ask questions directly to the person rather than to a companion, interpreter, or aide who might be accompanying that person.

Use first names only when socially appropriate, and when you extend the same familiarity to all others.

Ask questions when you are unsure of what to do.

Maintain eye contact without staring.

Use a natural tone of voice and body gestures.

If a person has a service dog or other assist animal, do not pet or otherwise distract the animal when it is working i.e., when the harness, jacket, special leash, or other designation is worn or displayed. If the person offers to let you interact with the assist animal, ask for direction in how to do so.

LANGUAGE CONSIDERATIONS

The way we describe people with disabilities, like other stigmatized minorities, has changed so the words we now use are more accurate and appropriate. Words and phrases we have used in the past have been factually incorrect or hurtful and should be avoided. A sampling of these words and phrases include: cripple, crippled, invalid, retard, sick, victim, afflicted, deaf mute, mute, deaf and dumb, wheelchair-bound, or confined to a wheelchair.

The language we use, and the images that we create and promote through language, reflect the attitudes we have towards any particular group of people. Our language is picked up and emulated by others around us. The preferred words and phrases show respect for the dignity of people with disabilities.

We sometimes make the mistake of speaking as if all people with a certain disability, or all people with disabilities, share the same characteristics, have the same needs, or think and act the same. We also use adjectives as if they were nouns; we speak of "the deaf" or "the blind." We refer to "blind people" or "a deaf accountant." Group designations such as "the blind," "the deaf," or "the disabled" are inappropriate because they do not reflect the individuality of people with disabilities.

When writing or speaking about people with disabilities, it is important to put the person first. Often, the focus is wrongly placed on the disability instead of on the person by naming the disability first. Some people describe this concept as "people-first" language where the individual is recognized as a person first, and then further defined in terms of his or her characteristic, disability, or functional limitation. Although this is sometimes verbally cumbersome or awkward or lengthy to write, you will not be wrong in speaking and writing thus. However, as with all other things, check with the person with whom you are interacting to see if he or she has a preference.

Some examples of "people first" language:

A person with... a physical disability, muscular dystrophy
A person who uses...a wheelchair, an interpreter, an assistive device
A person who is...Deaf, blind, autistic
A person who has... multiple sclerosis, cerebral palsy

Likewise, services and programs do not have disabilities, but they are provided for people who do. So we should not write or speak about "disabled services" and "handicapped parking." A better way to convey these ideas would be "services for people who are disabled" and "parking spaces designated for people with disabilities."

Do not feel guilty or embarrassed you can do something that he or she cannot. You can talk about things that a person may not be literally able to do. You can say to a person who is blind, "You have got to see that play," a person who is Deaf, "Did you hear about John?" or a person who uses a wheelchair or has a mobility disability, "Why don't we run over to the market."

Our attitudes towards people with disabilities are revealed when talking about people who are not disabled. When we say "able-bodied" or "normal," we must be aware of the implication and subtle message we are sending that says we feel people with disabilities are not "able" or "healthy" or are "abnormal." A more appropriate way to say this would be "people without disabilities" or "people who are not disabled." This also applies to programs or services provided for people who are not necessarily disabled that are described as, for example, "regular" with the implication that services provided to people with disabilities are "irregular." Instead, you might say, "typical" programs.

Not all people with disabilities agree on which language or terminology is preferred. Like any other large, diverse, yet identifiable group of people, individuals will vary as to how they refer to themselves and how they prefer others to refer to them. The suggestions given above will apply to most people and be correct in most situations. Some examples of other terminology that some people with disabilities have chosen to identify themselves as are "physically or mentally challenged" and "handicappers," while others still talk about themselves as "handicapped." It is important to remember that when talking to a person, ask what he or she prefers.

Here are some examples that exemplify these language principles:

USE: person with an intellectual, cognitive, or developmental disability
NOT: retard, mentally defective

USE: person who is Deaf or hard of hearing, unable to speak, or uses synthesized speech
NOT: the deaf, deaf and dumb, suffers a hearing loss, dumb,mute

USE: person who uses a wheelchair
NOT: confined or restricted to a wheelchair, wheelchair-bound

USE: person who has muscular dystrophy
NOT: stricken, afflicted, suffers from, or victimized by muscular dystrophy

USE: person with a physical disability or a person who has functional limitations
NOT: crippled, lame, deformed

USE: person with a psychiatric disability
NOT: crazy, nuts, "gone Postal"

USE: person who is successful or productive
NOT: has overcome his/her disability, is courageous (when it implies the person has courage because of having a disability), in spite of a disability

USE: person who is seeking accommodations or working accommodation issues
NOT: person who is having employment problems

ACQUIRED BRAIN INJURY

People with an Acquired Brain Injury

GENERAL INFORMATION

Acquired brain injury (ABI) can be caused by direct injury, external physical forces applied to the head, hemorrhage, swelling or may occur suddenly in the course of normal development. Other conditions that can result in a brain injury include heart attacks, aneurysms, chemical and drug reactions, breathing difficulties, infections, a car or other accident, and lack of oxygen to the brain. The injury may affect several areas of the brain and may be either closed or open head in nature.

In many cases, an ABI will result in an increased need for support in one or more of the following areas: physical capacities (i.e., the way we move and manipulate things); cognitive capacities (i.e., the way we think and process information); and behavioral and emotional capacities (i.e., the way we act, tolerate, and feel).

People who acquire brain injuries typically experience a variety of symptoms. These symptoms can vary in intensity over time, and could interact in unpredictable ways.

Physical Symptoms may include persistent headaches, fatigue, seizures, lack of motor coordination, weakness or involuntary muscle activity, double vision, partial loss of vision or hearing, delayed or difficult speech, sleeping disorders, and communication disabilities.

Cognitive Symptoms may include short and long-term memory loss, confusion, limited attention span, delayed response time, inability to make decisions, gaps in knowledge and skill, and difficulty managing two or more tasks simultaneously.

Behavioral/Emotional Symptoms may include inappropriate behavior, "disinhibition" (lack of inhibitions or appropriate boundaries), mood swings, depression, irritability, impulsivity, and denial of the disability. It should be noted that many individuals who have had an ABI experience some form of agitation during recovery.

With reasonable accommodations, though, all of these symptoms can, for the most part, be mitigated.

SUGGESTED BEHAVIORS

If the person's memory is affected, provide written information and instructions.

Break tasks into smaller sequential steps that are clear, consistent, and concise to increase understanding and remembering.

Verbally explain and demonstrate how to do a task.

Provide frequent feedback and recognize successes especially as new skills or gains are acquired.

Redirect a conversation that has gotten off track by using appropriate cues and reinforcers. For example, repeat important information about the purpose, duration, and guidelines of a meeting, or other type of gathering; summarize previous progress and review where previous meetings left off.

Follow-up spoken communications with a written communication (such as an e-mail or memo) to assist a person who may have memory support needs.

When asked to repeat a statement, use the same words and then paraphrase it for greater comprehension.

Provide only as much information or feedback as the person is capable of receiving and processing at any one time.

AMPUTATION

People Who Have Had an Amputation

GENERAL INFORMATION

Amputation is the removal of all or part of a limb. An amputation may occur as the result of an accident or as a surgical intervention for a medical condition. Most amputations are for people who have wounds that do not heal properly due to vascular disease, atherosclerosis, and blood clots. Amputation may also be carried out to prevent the spread of cancer in the lower end of a limb.

"Phantom pain" is a sensation felt by a person who has had a limb amputated. The sensation has been described as one of a compressing, contracting, or a bent feeling in the absent body part. Some individuals may also feel an aching or burning pain, where the extremity was. The sensation is caused by stimulation along a nerve pathway, where the sensory ending has been severed in the amputated body part. The pain usually lasts between 2 to 3 months after the amputation, although some individuals experience phantom pain for years.

Some persons who have had an amputation replace the missing limb with a prosthetic. Prosthetics vary greatly in appearance and function. Some are made to look like natural limbs, while others do not. Some prosthetic hands have a grasping device that looks much like a hook to manipulate objects. Prosthetic hands, arms, legs, and feet function much the same as natural limbs with similar flexibility, strength, range of motion, and function.

SUGGESTED BEHAVIORS

Think of the prosthetic limb or device as you would a natural hand, arm, or leg.

When introduced to a person with a metal grasping device or an artificial hand, it is appropriate to offer to shake the device or artificial hand.

Some people who have nonfunctioning or missing right hands prefer to shake hands with their left hand. Take your cue from the individual.

If the person does not have arms, it is appropriate to gently grasp his or her shoulder in a collegial manner or device in lieu of shaking hands.

ATTENTION DEFICIT DISORDER

People Who Have an Attention Deficit Disorder or an Attention Deficit Hyperactivity Disorder

GENERAL INFORMATION

Attention Deficit Disorder (ADD) is defined as a persistent pattern of inattention that is more frequent and severe than behavior seen in individuals of a similar age. Add hyperactivity and impulsiveness to this condition, and you get an individual with Attention Deficit Hyperactivity Disorder (ADHD). This section will focus primarily on individuals with ADHD because that is the more severe of the two conditions. There are many more factors involved with ADHD than ADD. So, while this section will focus mainly on ADHD, the information does, for the most part, apply to an individual with ADD as well. Both conditions generally have an onset prior to the age of seven, but symptoms may be diagnosed at an earlier age, or not until the individual is an adult.

The exact cause of ADD and ADHD is not known at this time, but researchers have found that they are neurologically based. The conditions lie in a person's neurotransmitters – the chemicals that regulate brain behavior.

ADHD and ADD are not a learning disabilities. ADHD is a behavioral condition that is characterized by impulsiveness and an inability to pay attention for more than a set period of time. This attention span varies with each individual. The condition might cause some individuals to make mistakes on the job, but these mistakes are usually a result of their ADHD, not a reflection on their ability to learn. This differs from learning disabilities, which refer to specific developmental disorders associated with learning and the ability to process or interpret information.

While adults with ADHD might find it challenging to focus their attention for extended periods of time or to organize their offices, desks and materials, most are able to effectively find coping mechanisms that help them to adapt to their disability, and they can and do thrive professionally. Thus, there should be no ADHD-related barriers to increased responsibilities and career development. As such, there is no need to restrict the nature or the amount of work that is assigned to a person with ADHD.

One effective, coping mechanism is to maintain a structured, consistent, predictable daily schedule. It may also be helpful if the employee is able to limit the number and kinds of distractions in his or her work area.

SUGGESTED BEHAVIORS

Communicate in direct, clear terms. Be patient, specific, and consistent. Apply structure whenever possible in communication and work tasks.

Ask clarifying questions throughout the conversation to ensure that the person is grasping the information provided. Repetition may be necessary.

For new employees, clearly state expectations, policies, and procedures, as well as both defined and "hidden" rules in the organization.

Allow for several short breaks during a long meeting or workshop rather than one long break. People with ADHD have the most difficulty in situations that require prolonged periods of attention.

AUDITORY

People Who Are Deaf or Hard Of Hearing

General Information

The term "deaf" refers to a profound loss of hearing. Persons are considered deaf if they are unable to hear or understand speech and must rely on vision for communication. The term "hard of hearing" refers to a hearing loss from mild (i.e., difficulty with or inability to hear soft sounds) to severe (i.e., difficulty with or inability to hear loud sounds). The severity of a person's hearing loss may be different at various frequencies. Also, the ability to hear a voice might be different from the ability to discriminate between sounds and to understand speech. Some people cannot hear voices but can hear environmental sounds.

Deafness is unlike other disabilities in that the same term is used to refer to two distinct groups of people. Those who consider themselves "deaf" (written with a lower-case "d") have a profound hearing loss but identify primarily with the hearing culture. Those who consider themselves "Deaf" (written with an upper-case "D") consider themselves to be a member of the Deaf Community, which generally perceives hearing loss to be a cultural and communication distinction rather than disability. These communities no longer commonly use the term "hearing impaired."

People who refer to themselves as "Deaf" often have Deaf parents and have attended state schools for children who are Deaf. For this population, American Sign Language (ASL) is the primary language. ASL is a linguistically recognized language with its own vocabulary, grammatical rules, and syntax that allows users to express themselves fully. It employs a subtle combination of hand, face, and body movements to convey messages. ASL is a completely separate language from English and follows neither the word order nor grammar rules of English. It is important to remember that, for people who use ASL as their primary language, English is a second language. Just as in the general population, the ease and competence with which someone learns a "second language" varies widely.

ASL is not a universal sign language. People who are Deaf from other countries use their own unique culturally determined Sign Language such as French Sign Language or Spanish Sign Language.

Some people who embrace their Deaf culture take pride in their deafness and do not necessarily seek to be integrated into the hearing world. They celebrate their Deaf experience through drama, poetry, storytelling, dance and other uniquely Deaf art forms that are passed down from one generation to the next.

People who refer to themselves as "deaf" often relate more easily with the hearing culture. Often these people have hearing parents and have attended public schools in mainstreamed classes. People who are deaf typically do not use ASL as their primary communication method. Instead, they use an English-based sign system to communicate with each other and with hearing people who know that communication method.

Persons who lose their hearing later in life, sometimes referred to as "late deafened," may have different communication preferences and rely on residual hearing, lipreading, captioning, or perhaps an English-based sign system.

The ability and facility to communicate orally often depends on when the individual became deaf. People who lost their hearing after the development of their speaking skills may have little difficulty speaking. In contrast people who were born without hearing, or who lost it at a very early age, may experience difficulty in learning to speak, though this is not always the case. Because speech develops as one listens to others and imitates the sounds heard, vocal communication can be more complicated for people who have never heard speech than for those whose hearing loss developed later in life. Many persons who have a hearing loss learn to use their voices in speech class and prefer to communicate vocally. Others choose to communicate in variety of other ways, including sign language, speechreading (also known as lipreading), cued speech, and writing.

People with a hearing loss communicate with people who are hearing in a variety of ways. Some do so with assistive technology, such as Assistive Listening Devices, Cochlear Implants, or reliance on various kinds of hearing aids. Assistive Listening Devices include large and small area amplification of spoken speech. Very simply stated, Cochlear Implants are surgically embedded devices that change the acoustic signal of sound into an electrical stimulus. Through both external and internal devices the auditory nerve is stimulated and that information is transmitted to the brain.

Assistive technology that presents a text rendition of spoken language includes CART (Computer Assisted Real Time Captioning) and another method called "C-Print Captioning." Both of these methods utilize a hearing person who listens to the speaker, inputs the spoken word into an electronic word processor, and produces written English onto a screen or other kind of display.

Individuals with a hearing loss sometimes use a telephone relay service. The relay service operator communicates with the person with a hearing loss through a TTY (a telecommunications device for people with a hearing loss or have speech disabilities) and with the person who is hearing through the telephone. The operator, who is not an interpreter, voices the TTY message and types the spoken message between the participants in the conversation.

A relatively new technology allows for Video Relay services where a qualified interpreter, in a remote location, communicates with the person with a hearing loss via the Internet with a web camera and the person who is hearing through the telephone and provides interpreting services between the two individuals.

Many people with a hearing loss prefer to use a qualified professional interpreter to facilitate communication. The need for an interpreter depends on the situation and the people involved. The term interpreter here is meant as a general term for both interpreters and transliterators.

A qualified interpreter facilitates and culturally mediates communication between people who do not share a common language or means of exchanging messages. Interpreters bridge this communication gap by rendering the message of one person to another in the most appropriate language for the participating consumers. This communication need is shared by all of the persons involved. Interpreters transmit messages using one or more of the following modes of communication: spoken English, ASL, an English based sign system, cued speech, or the oral method (utilizing lip movements, but no voice and no signs). The mode is fundamentally dependent on the preference of the individual with a hearing loss.

Professional certified interpreters all follow a Code of Ethics developed by their certifying organization. While there are some differences among various codes, which are reviewed and revised from time to time, virtually all of the codes share some basic concepts. These concepts most likely will include, but are not limited to, confidentiality, faithful rendering of the message, non-intervention, discretion when accepting assignments, competency, integrity, compensation, appropriate behavior, responsiveness to consumers, and professional development.

The two national certifying bodies for professional interpreters, the Registry of Interpreters for the Deaf (RID) and the National Association of the Deaf (NAD), have recently formed the National Council on Interpreting (NCI) to develop a National Interpreter Certification (NIC) test. This new test replaces certain RID and NAD certification testing. Certification will be awarded by the NIC.

If the person with a hearing loss chooses to use an interpreter, here are some guidelines that will facilitate the process.

COMMUNICATING THROUGH AN INTERPRETER:

When using an interpreter, communicate directly with the person with a hearing loss, rather than speaking as if he or she were not there. Avoid phrases such as, "tell him..." Ask questions directly of the person with a hearing loss, e.g., "How do you feel about that?" Talk to, not about, the person with a hearing loss. Talk through, not to, the interpreter.

Maintain eye contact with the person with a hearing loss, even as he or she is looking at the interpreter.

At times, the person with a hearing loss may prefer to have the interpreter voice the message that is communicated in sign. If this is the case, remember to respond to the person with the hearing loss, not the interpreter. Sometimes the gender of the person with a hearing loss is different from the interpreter. Do not be confused by this, especially on the telephone.

Be aware that the interpreter is there only to facilitate communication, not to participate in the conversation or activity.

The person with a hearing loss should be consulted about where to place the interpreter. This will usually be in a well-lit area near the speaker. The person with a hearing loss should have a clear view of the interpreter and any visual aids the speaker may use. Avoid bright lights or colors directly behind the interpreter.

Adequate lighting is necessary at all times, especially when the room is darkened.

Speak at a customary rate of speed, in a natural tone, and using usual speech patterns.

As the interpreter will be a few words behind the speaker, allow additional time for questions before continuing during a conversation, meeting, or workshop.

Be mindful that the person with a hearing loss cannot watch the interpreter and look at visuals simultaneously. Therefore, allow time for people to look in each direction.

The person watching the interpreter usually cannot take notes simultaneously so it is helpful to provide written instructions, directions, or notes when possible. In a meeting, a volunteer note-taker (perhaps a co-worker or clerical assistant) will be extremely helpful.

When planning a meeting or event, find out the preferred communication mode of the person with a hearing loss, if possible, in order to obtain the most appropriate interpreting services. In some specialized situations, a person with a hearing loss may prefer CART or C-Print captioning instead of a sign language interpreter.

Provide as much information about the meeting to participants, CART or C-Print Captioning providers, and sign language interpreters prior to the meeting time including acronyms, specialized vocabulary, correct spelling of names, agendas, and speakers' notes or prepared remarks.

SUGGESTED BEHAVIORS

To get the attention of a person with a hearing loss, vocalize a greeting, and if necessary, discreetly wave your hand or gently tap the person's shoulder. If you are entering his or her office and the person's back is to you, you could flicker the room lights. Wildly gesticulating, hitting the person, or throwing objects at the person is not appropriate.

When speaking to an individual with a hearing loss, use meaningful facial expressions and gestures to emphasize your intent and attitude. This helps to visually display your tone of voice. Try to find a quiet place away from computers, telephones, and other sources of noise that has adequate lighting.

Pen and paper are handy communication devices in some situations.

Although you want to avoid gross or exaggerated arm waving, pantomime is sometimes helpful.

Be aware that if you point to an object or area during a conversation with a person with a hearing loss, that person will most likely turn to look at where you are pointing. Wait to resume speaking until the person faces you again.

When talking to an individual with a hearing loss, position yourself so that any bright sunlight or other light is in front of you rather than in back of you. Keep your face out of shadows. Illuminate your face as much as possible.

Remove from your mouth objects such as pens, pencils, gum, or food. Keep your hands or any other objects from covering your mouth.

If a person is speaking for himself or herself and you do not understand that person's speech, it is appropriate for you to ask him or her to repeat, or even write down what was said.

If the person has difficulty understanding something you've said, try repeating the phrase. If your message is still not understood, try to rephrase your thought rather than repeating the same words. Do not raise your voice or yell because the essential barrier is not the person hearing you, it is the person understanding you. If needed, jot the phrase down on paper.

Not all individuals with a hearing loss can lipread, but many do and some do it quite well. Even good lipreaders, though, sometimes miss words. It is important to check with the person to make sure you are communicating effectively. When a person is lipreading you, enunciate clearly, but do not overenunciate your

words, as you will distort your lip movements and make understanding more difficult. Use your voice when talking to the person so that your lip movements will be more natural and the person can use his or her residual hearing for better understanding.

Face the person when conversing so he or she can augment communication by lipreading.

Try to learn some elementary or "survival" sign language and fingerspelling from colleagues, coworkers, or managers who have a hearing loss. Another resource could be interpreters or other people skilled in sign language.

If you telephone a person who is hard of hearing, let the phone ring longer than usual. Speak clearly and be prepared to repeat who you are, and the reason for the call.

When talking with a person with a hearing loss, explain any interruption (such as a phone ringing or knock at the door) before attending to it.

Provide written notices of events that are usually announced orally. Arrange to have messages that are delivered by a public address system relayed in writing.

At meetings, strive to enforce the process of only one person speaking at a time. Some meeting facilitators use a small object such as a ball or gavel to indicate whose turn it is to speak. This allows the person with a hearing loss to easily identify who is speaking.

Provide paper and pencils at all tables to facilitate communication.

E-mail is a better way to communicate than voice mail. Make use of "Instant Messaging" (IM) technology.

In meetings or on conference calls, each individual should identify himself or herself by name to facilitate understanding, flow of ideas, and exchange of information.

COGNITIVE

People Who Have a Cognitive Disability

GENERAL INFORMATION

"Cognition" refers to the ability to comprehend what you see and hear, and to infer information from social cues and body language. People with impaired cognitive functions may have trouble learning new things, generalizing from one situation to another, and expressing themselves through spoken or written language. Cognitive disabilities are sometimes referred to as "developmental disabilities" because they are manifested before the person reaches adulthood and they affect cognitive development. As children, people with these kinds of disabilities might have been classified in school with one of the following conditions: learning disability, mental retardation (now called intellectual disability), autism, multiple disabilities, having a head injury, or Down syndrome.

When working with someone whose cognitive functioning is different from yours, it is important to distinguish between learning and working style preferences and disabilities.

People with Autism have a complex neurological disability that affects the functioning of the brain, which typically appears during the first three years of life. Autism ranges from mild to severe. Typically, people with autism have some difficulties in verbal and non-verbal communication, processing information, social interactions, and leisure or play activities. They may exhibit repeated body movements (such as hand flapping or rocking), unusual responses to people or attachments to objects, and resistance to changes in routines. However, autism does not affect intelligence. Therefore, many people with autism function very well in the workplace and can perform the duties of virtually any job.

People with Intellectual Disabilities (formerly mental retardation) may have average or superior abilities in some areas, while at the same time, are slower to learn or retain skills in other respects. Intellectual disability should not be confused with psychiatric disability, learning disability, or behavioral and emotional disability.

While it is true that some people with an intellectual disability are not able to think, reason, or remember as well as others, the effects of the disability can be lessened. Skills and abilities are increased through rehabilitation, education, and experience on the job.

Most people with an intellectual disability want to be independent and responsible for their own support. For them, success on the job often depends upon the willingness of coworkers to devote reasonable time and interest to helping these individuals adjust initially and meet new challenges as they arise.

To achieve workplace success, some people with an intellectual disability may utilize a "job coach" to facilitate and support their mastery over assigned tasks. This "supported employment" model helps the employee navigate the workplace.

SUGGESTED BEHAVIORS

Cognitive Disabilities -- in general

Be prepared to repeat what you say – orally, in writing, or using multiple formats -- to communicate with the person.

Offer assistance in understanding written instructions and in completing forms or documents.

Provide extra time for decision-making.

Be patient, flexible, and supportive. Take time to listen to, and understand the individual and make sure the individual understands you.

Adjust the length of conversations to maximize the individual's ability to remain attentive and decrease stress level.

Give instructions and have discussions in a quiet, informal, distraction-free environment.

Describe job tasks clearly, concisely, and simply. Break down large tasks into clearly defined small, sequential steps, keeping verbal descriptions short and direct. Use concrete terms and avoid abstract ideas

Establish tasks that include a set routine and consistent work.

People Who Have Autism

Remember that the person may have difficulty making eye contact and interpreting nonverbal cues, such as facial expression, gestures, and tone of voice in social settings

Be aware the person may be sensitive to touch, sounds, light, or color.

Be aware the person may tend to focus or fixate on particular objects or topics of discussion.

Be aware the person may quietly talk to himself or herself frequently throughout the day.

As the degree of impact of the disability varies tremendously with each individual, it helps to ask the person for advice and guidance in setting up his or her work environment. Things to consider would be the amount of noise, light, and other distractions in the person's work area.

Be aware the person may be socially awkward and may appear to be eccentric or different.

As the person may have difficulty interpreting nonverbal cues, direct, specific, and clear communication is important.

People Who Have an Intellectual Disability

Simplify and minimize wording in written and oral communications, but be sure to retain the original meaning.

Periodically, ask the person if he or she understands you. Have him or her paraphrase the meaning of your words and ideas to confirm this. Likewise, repeat information back to the individual to show that you understood what was said.

Routine and consistent job duties are usually the easiest to master. Add new responsibilities only after previous duties have been learned. Provide lists or checklists of job duties to help the person work independently.

Ask the person how he or she learns best and can stay on track.

Demonstrate what needs to be done, and then let the person practice with guidance and corrections from you.

EPILEPSY

People with Epilepsy or Other Seizure Disorder

GENERAL INFORMATION

A seizure occurs when there is a sudden electrical discharge in the brain. Each individual is uniquely affected. A seizure can result in a relatively slight reaction, such as a short lapse in attention, to a more severe reaction, such as a loss of consciousness. Some seizure disorders can be controlled with medication; however, side effects of the medication may make the person lethargic or slow their reaction time to situations. When controlled by medication, seizure episodes in the workplace are rare. If a person discloses that he or she has such a disorder, ask what to do in case of a seizure.

SUGGESTED BEHAVIORS

If a person is having a seizure, stay calm.

If the seizure lasts beyond a few minutes, or if the person seems to pass from one seizure to another or does not regain consciousness after the seizure episode ends, call for emergency assistance.

When the seizure begins, help ease the person to the floor.

Do not try to stop the seizure. Do not try to "revive" the person during the seizure.

Let the seizure run its course.

Do not move the person unless the environment in which the seizure occurring is clearly dangerous.

Remove hard, sharp, or hot objects from the vicinity of the person to avoid injuries, but do not interfere with the person's movements.

Loosen the person's tight clothing and remove his or her glasses.

Do not put your hand or any hard implement in the person's mouth to hold down the tongue. Contrary to popular belief, the tongue cannot be swallowed.

Make sure that breathing is unobstructed but do not be concerned if breathing is slightly irregular.

HIV and AIDS

People Who Have an HIV Infection or AIDS

GENERAL INFORMATION

Medical and public health authorities have established that HIV infection cannot be transmitted through casual, social contact as exists in the vast majority of workplaces. Nor is HIV infection transmissible through food or food handling. As a result, HIV transmission in the workplace will rarely constitute a direct threat.

Workplace education emphasizing the fact that HIV and AIDS are not transmitted by casual contact affords an employee a supportive atmosphere in which to work. It will also serve to reassure co-workers that they are not at risk and help preserve workforce productivity.

It is important to maintain confidentiality about any individual, but our society has shown this to be particularly critical when considering a person with HIV or AIDS.

SUGGESTED BEHAVIORS

The Centers for Disease Control and Prevention has stated that you cannot contract HIV through casual contact. Your interaction should reflect this understanding.

Be mindful that close co-workers, friends, and family members might feel the stigma that is sometimes attached to persons with HIV or AIDS.

Do not pity, overreact, or be paternalistic to a person with AIDS or HIV.

Because HIV and AIDS may be contracted in various ways, do not presume to know the lifestyle of a person with AIDS or HIV.

LEARNING DISABILITIES

People with a Learning Disability

GENERAL INFORMATION

The term "learning disability" is used to describe a variety of neurological disorders in acquiring, storing, retrieving, or expressing information. In other words, learning disabilities involve speaking, writing, or understanding in persons who have average or above average intelligence. Manifestations include difficulty in oral expression, listening comprehension, thinking, interpreting information, reading skills, reading comprehension, written expression, spelling, reasoning, organization skills, problem solving, or doing mathematical calculations. A learning disability can also affect the social aspects of a person's life such as team participation and interpersonal relationships.

Although its impact can be lessened somewhat as a person develops and learns adaptive techniques, a learning disability is a life-long condition. A person is very likely to have a combination of two or more learning disabilities in varying degrees rather than only one type. Also, the instance of learning disabilities with Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder being present at the same time is quite common.

It is not always apparent that a person has a learning disability. A possible indication that a person has a learning disability is when he or she performs in a way that seems inconsistent with his or her intelligence or personality. For example, employees with unrecognized learning disabilities may be perceived as clumsy, inefficient, accident-prone, unmotivated, careless, slow, distracted, or inattentive. In addition, they may seem to lack social skills or emotional maturity.

People with learning disabilities must discover their own personal coping mechanisms to accommodate their specific learning disability. Just as learning disabilities are unique, so too, are coping mechanisms. Alternative work strategies can help people with learning disabilities adapt. Once they learn new skills in an appropriate manner, they generally perform to their maximum capability.

Some common types of specific learning disabilities that have been identified are academic, perceptual, and motor. These types often overlap in the way they are manifested.

The academic learning disabilities and the difficulties they present include Dyslexia, reading; Dysgraphia, writing; Dysphasia, speaking; and Dyscalculia, math.

The employee who has severe dyslexia, for example, often reads printed matter by using computers and calculators with artificial speech. They may ask another individual to read to them or they use audiotapes to gather information. They usually prefer verbal rather than written instructions.

Coping mechanisms for other learning disabilities follow similar patterns of identifying the disability, and finding ways to work around the barriers imposed by the disability.

People who have a perceptual learning disability have difficulty receiving information through their senses. This includes auditory, tactile and visual perception.

People with motor learning disabilities experience difficulty when their muscles react differently than expected to brain signals, resulting in a lack of coordination. Other learning disabilities involve attention deficit, balance, crossing the midline (going from the one side of the body to the other side of the body), directionality, lack of inhibition, short-term memory, and social skills.

SUGGESTED BEHAVIORS

Explain the organization's unique culture or "politics" and the relationship between organizations and individuals, including the "hidden" rules by which organizations or individuals operate. Openly discuss the rules of "turf" and "territory" that other employees might instinctively perceive and understand.

Recognize that some people with learning disabilities, especially when not diagnosed, experience feelings of frustration, anger, inadequacy, and low self-esteem. Once diagnosed, it is important to recognize these feelings as being a result of the learning disability and to address them openly and honestly.

Be firm about any limits that are set.

If inappropriate behavior is observed or reported, tell the person exactly what behavior is inappropriate and what changes need to be made.

Reduce distractions and unnecessary visual and auditory stimulation.

Be thorough, direct, and specific in communication. Ask questions to insure understanding. Allow adequate time for a response.

When giving instructions or directions, break large tasks into small and clearly defined sequential steps.

Demonstrate how to do a task in addition to explaining it verbally.

Give frequent and constructive feedback.

Allow adequate time to learn certain skills.

Whenever possible, notify the person of changes well in advance.

Decide together the preferred way to communicate. This may be in writing, verbally, or even by telephone.

For the employee who has difficulty with visual perception, it is important to have neat and well-organized surroundings.

For people who read slowly, give advance notice of reading materials, allow extra time, and prioritize the work. Audiotape written communications. Provide graphic presentations such as diagrams and flow charts when appropriate.

For people with auditory perception difficulties, catch their eye before beginning a conversation. Talk in a quiet place. Ask them to repeat what you said. If they take notes, allow them to finish writing before you continue talking.

MOBILITY

People Who Have a Mobility Disability

GENERAL INFORMATION

Mobility disabilities include a broad range of disabilities that affect a person's independent movement. Mobility disabilities may result from cerebral palsy, spinal cord injury, stroke, arthritis, muscular dystrophy, multiple sclerosis, amputation, polio, or other conditions resulting in paralysis, muscle weakness, nerve damage, stiffness of the joints, strength and endurance, short stature, conditions like Osteogenesis Imperfecta ("brittle bones"), or lack of balance or coordination.

Some people with mobility disabilities use manual or power wheelchairs, while others use a variety of mobility aides, such as crutches, canes, walkers, or scooters. Not every person who uses a wheelchair or other mobility device is unable to walk; many use these devices to conserve their energy, or to cover long distances. Prosthetic devices, such as artificial arms or legs, and body braces might also be used. Some people with mobility disabilities use service animals to assist them with carrying or retrieving items and opening doors in order to achieve greater independence.

The conditions that cause mobility disabilities have their own distinct characteristics. Some mobility disabilities are acquired at birth, while others are caused by accidents, illnesses, or the natural process of aging. People with mobility disabilities have highly diverse levels of physical ability and range of motion.

A major cause of mobility disability is spinal cord injury and disease. Causes include motor vehicle accidents, falls, and sports injuries, such as diving accidents. Other causes of damage to the spinal cord include conditions such as polio and spina bifida.

Spinal cord injuries can be either complete, meaning that there is no sensation or voluntary movement below the injury, or incomplete, meaning that there is some functioning below the injury. In addition to a lack of muscle control and/or sensation, people with a spinal cord injury may experience loss of involuntary functions such as unassisted breathing or body temperature control, as well as chronic pain.

Although many people who are paralyzed cannot experience certain sensations, there are many forms of spinal cord injuries resulting in varying levels of movement and sensation. For example, it is possible for someone with a spinal cord injury to have no muscle control of his or her lower extremities, but to have sensation to touch.

People with a mobility disability who use a wheelchair do so for a variety of reasons. Each person may have different needs and physical abilities.

Some people with a mobility disability, including paraplegia (commonly, paralysis of the lower body), who use a wheelchair will need to stretch and relieve pressure from time to time by slightly lifting themselves off the chair with their arms. This is done to stimulate circulation.

Do not be surprised if the person transfers from a wheelchair to a ergonomically superior stationary chair or gets out of the wheelchair to move about. Many people who use wheelchairs can walk with or without the aid of canes, braces, or crutches, but their speed, range, and convenience of movement is enhanced by the use of wheelchairs and scooters. People who use wheelchairs participate in many different physical activities such as swimming, skiing, driving and other activities both in and out of their wheelchair.

Mobility is also an issue for individuals with short stature. There are literally hundreds of medical or genetic conditions that cause short stature, that is, a person who is approximately 4 feet 10 inches or shorter. The most common is Achondroplasia. A person with this condition has arms and legs that are short when compared to the trunk length. This shortness is particularly noticeable in the upper arms and thighs. Other persons with short stature have proportional arms and legs when compared with the trunk of the body. Mobility issues include walking and climbing steps with a shorter stride, while communication issues involve face-to-face interactions.

Schedule meetings at convenient accessible locations so the person doesn't have to take a long and indirect route to get there. Give clear instructions on how to reach a destination, using the shortest and most accessible route. Make sure there are accessible bathrooms near meeting locations. Floor or ground surfaces should be free of obstacles that would inhibit the movements of people with a mobility disability. Provide convenient places to sit at meetings or other group activities.

SUGGESTED BEHAVIORS

If a person uses crutches, a walker, a cane, or some other assistive equipment, offer assistance with coats, bags, or other belongings.

If you call a person with a mobility disability, allow the phone to ring longer than usual to allow extra time for her or him to reach the telephone.

The use of touch with a person using a wheelchair (e.g., a pat on the shoulder or arm to show support) adheres to the same rules as when touching a person not using a wheelchair. In short, use common sense and be respectful.

When walking with a person who walks slower than you, walk alongside and not in front of the person.

If a person falls or is off balance, simply offer assistance. A natural tendency is to overreact, but you need not be overprotective of a person with a mobility disability.

Offer to shake hands even if the person appears to have little hand strength or movement.

Do not hold on to a person's wheelchair. It is a part of the person's body space and holding on is both inappropriate and dangerous.

Talk directly to the person using the wheelchair, not to a companion or other third party.

It is appropriate to offer to assist with a particular task such as opening a door, loading a wheelchair into a car, or pushing it up a steep hill, but do not be offended if your help is not accepted. Never assume the person needs your assistance and start grabbing or pushing his or her wheelchair.

If the person uses a cane or crutches, the person will want to keep them within reach. If, however, they are in the way or pose a tripping danger, it's fine to ask the person to move them under the chair or desk.

As the person may have decreased physical stamina and endurance, finding a place to sit and talk is preferable to standing during the entire interaction.

When conversing, place yourself at eye level with the person. Some ways to accomplish this without drawing attention to yourself are kneeling, sitting on a chair, or standing a little farther away to reduce the steep angle of the sightline. This is effective when interacting with all people who are sitting as well as persons with short stature.

If the person's speech is difficult to understand, do not hesitate to ask him or her to repeat what was said. Never pretend you understand when you do not.

If a person chooses to communicate using assistive technology, such as an augmentative communication device, be patient with the speed of the technology. Though not generally done, some individuals may not mind having his or her sentences finished by you in order to ease communication. Absolutely confirm this, though, before doing it.

Some people with paraplegia, quadriplegia, or other disabilities may have difficulty in holding a pen or in writing. Although you should not assume so, the individual may want or need your assistance in this task and ask for it. If this is

the case, ask how you can best assist him or her. For example say, "If you would like assistance, I am available to help you fill out the form."

Do not physically lift or manipulate a person with a mobility disability in any manner against his or her will.

MUSCULAR/NEUROLOGICAL

People Who Have a Muscular/Neurological Condition

GENERAL INFORMATION

Muscular or neurological disabilities can affect motor ability and/or speech. A person with such a disability may exhibit some involuntary or halting movement or limitation of movement in one or more than one appendage, as well as some lisping, indistinct speech, lack of saliva control, or flatness of tone due to lack of fine motor control of the tongue and lips. The severity and functional effects of the disability vary from person to person.

Cerebral Palsy is a condition caused by damage to the brain, usually occurring before, during, or shortly after birth. Cerebral palsy is characterized by an inability to fully control motor functions. This may include stiff or difficult movements; involuntary and uncontrolled movements; involuntary spasms; impairments in sight, hearing or speech; a disturbed sense of balance and depth perception; difficulty in maintaining balance; unsteady or irregular gait, or mobility impairments. Because of these traits, some people with cerebral palsy might appear to be under the influence of alcohol or drugs when they are not. Cerebral palsy does not affect intelligence, though it may co-exist with an intellectual disability.

Some people who have significant cerebral palsy or other muscular or neurological disabilities may communicate with the aid of assistive technology, such as typing, or using a communication board or other electronic device.

Multiple Sclerosis (MS) is a condition of the brain and spinal cord (Central Nervous System) in which the covering of the nerves is destroyed. This condition impedes the communication between the brain and spinal cord, thus creating a multitude of different symptoms.

Although each case of MS is unique, typical symptoms include difficulty with balance and coordination, fatigue, tremors and spasms, pain, weakness, numbness, tingling, and weakness or other reactions to hot or cold weather conditions or room temperature. Vision, hearing, and/or speech might also be affected. In some cases, the symptoms become gradually more severe, while in others there may be a pattern of exacerbation followed by complete or partial remission.

Muscular Dystrophy (MD) is the common name for several progressive hereditary conditions, including Amyotrophic Lateral Sclerosis (ALS), which cause muscles to weaken and degenerate. MD is caused by altered genes, which prevent the body from manufacturing essential substances in adequate amounts to maintain and fuel the muscles.

Since MD encompasses many conditions, the symptoms will vary with the type. However, some symptoms are prevalent in many of the conditions. These symptoms include, but are not limited to, generalized weakness, muscle atrophy, or paralysis affecting limb and trunk muscles, as well as a person's face, feet, hands, or neck. Sometimes respiratory muscles are also affected.

A Stroke is a brain injury caused by a sudden interruption of blood flow to the brain. When an area of the brain is damaged by stroke, functions controlled by that area no longer work as they previously did. There are four areas of brain function that can be affected by stroke: motor control, sensation, communication/cognition, and personality. People who survive a stroke often have weakness on one side of the body. They also might experience a variety of disabling effects such as partial or full paralysis of the body, memory loss, or speech difficulties.

Many of the conditions caused by stroke can be significantly improved with rehabilitation. Through physical, occupational, recreational, speech, and other therapies, people who have had a stroke can enhance their functional abilities and live and work independently.

SUGGESTED BEHAVIORS

If the person's speech is difficult to understand, ask him or her to repeat what was said. Never pretend to understand when you do not.

If a person chooses to communicate using assistive technology, such as an augmentative communication device, be patient with the speed of the technology. Though not generally done, some individuals may not mind having his or her sentences finished by you in order to ease communication. Absolutely confirm this, though, before doing it.

Some people with muscular or neurological disabilities may have difficulty holding a pen or writing. If this is the case, do not assume anything, but rather ask how you can be of assistance. For example say, "If you would like assistance, I am available to help you fill out the form." Do not say, "Oh, you cannot do that, I will do it for you."

When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use can usually shake hands. Shaking hands with the left hand is an acceptable greeting.

PSYCHIATRIC

People with, or History of, a Psychiatric Disability

GENERAL INFORMATION

Psychiatric disabilities cover a wide range of behavioral, emotional, or psychological conditions. These include anxiety disorders, major depression, bi-polar disorders, (formerly called manic-depressive illness), schizophrenia, as well as, personality, disassociative and post-traumatic stress disorders.

Not all causes of psychiatric disabilities are known, but it is generally believed that these disorders are due to a combination of biochemical, psychological, and environmental factors. They can interfere with a person's ability to think, feel, and interact with or relate to other people and the environment. Many of these conditions can be treated successfully with medication and treatment.

Psychiatric disabilities are often not apparent. Supervisors will probably not know whether an employee has a psychiatric disability unless he or she chooses to disclose it. Supervisors should be aware, though, that a noticeable change in a person's work habits, level of accomplishment, quality of work, or interpersonal relationships with colleagues and managers, may be an indication of a psychiatric disability. Supervisors and managers are encouraged to seek guidance and assistance from the Employee Assistance Program (EAP) and the Equal Opportunity Programs Office (EOPO) if they notice these changes.

The symptoms of psychiatric disabilities manifest themselves differently depending on the type of disorder and the unique traits and support systems of the individual. For example, some workers with psychiatric disabilities find it difficult to concentrate while workers who take medications to control their psychiatric symptoms may experience side effects such as hand tremors, excessive thirst, or blurred vision. Some individuals report difficulty in focusing on multiple tasks simultaneously, particularly amid noise and distractions. Other employees find it difficult or impossible just to get out of bed and come to work.

While it is not unusual for many people to feel anxious during times of stress, people with anxiety disorders experience feelings of excessive anxiety and overwhelming fears that interfere with their usual daily activities. Anxiety disorders include generalized anxiety disorder, panic disorder, post-traumatic stress disorder, obsessive-compulsive disorder, as well as social and other phobias.

Depression is probably the most commonly diagnosed psychiatric disability. Clinical depression is characterized by a loss of energy, sleep disturbances, changes in appetite, and feelings of hopelessness that are experienced

continually for more than two weeks. Depressive illnesses include major depression, dysthymic disorder, atypical depression, and manic depression/bi-polar disorder.

Schizophrenia is among the more severe forms of psychiatric disability. It generally refers to a psychotic disorder characterized by a loss of contact with the environment and a disintegration of personality. Even though this condition cannot be cured, it can be controlled with medication and psychotherapy. Psychiatric disability does not affect a person's intelligence. However, sometimes during adjustment periods to medications, people with psychiatric disabilities may appear lethargic. Some people with psychiatric disabilities may experience difficulties with their attention span or discussing topics that produce anxiety. Some individuals may have difficulty processing or expressing emotions or might overreact to emotionally charged topics. All of these behaviors can result in miscommunication.

Although some psychiatric disabilities include symptoms of aggressive behavior, people with these disabilities are generally no more violent than anyone else. If violent behaviors are part of a person's specific condition, they can usually be controlled with medication and psychotherapy.

Applicants and employees are often deterred from discussing their psychiatric disabilities with employers because of the stigma often associated with these disorders. Disclosure is a personal decision on the part of the worker that involves many factors including trust, comfort with others in the workplace, job security, and the perceived open-mindedness and support of the immediate supervisor.

Sometimes it is difficult to share an office if you have a psychiatric disability because of the communication and interpersonal dynamics of having an office mate. Therefore, if possible, it might be better for an employee with a psychiatric disability to have his or her own office.

SUGGESTED BEHAVIORS

Be sensitive to requests for a flexible work schedule to allow the person to attend medical appointments and therapy sessions and to deal with medication issues, insomnia, fatigue, or other conditions that often accompany psychiatric disabilities.

Through your own behavior and demeanor, show that you trust the individual's ability to control his or her behavior.

Integrate the person fully into office activities.

If the person makes an occasional odd statement, try to just agree or let the comment pass. Simply help redirect the person to the topic or task.

Minimize stress for the employee as much as possible.

Approach each employee with an open mind about his or her strengths and abilities.

Convey important information objectively and avoid using sarcasm and giving mixed messages. Talk to the individual in a calm and relaxed manner. Make sure that any instructions are defined carefully and clearly. Repeat or summarize information and write it down for the person's reference when needed. Explain things even though they may seem obvious to you.

Clearly express expectations for performance. Maintain continuous communication with the individual, providing timely feedback on a regular basis. Do not assume the employee knows when he or she is doing either well or poorly.

Be firm, fair, flexible, and consistent, especially in administering policies and work assignments.

SPEECH

People Who Have a Speech Disability Including People Who Stutter

GENERAL INFORMATION

Speech disabilities range from slight to severe. The disability may be related to another condition such as cerebral palsy, a brain injury, stroke, or hearing loss. Stuttering is also considered to be a speech disability.

Individuals with a speech disability sometimes use a telephone relay service. The relay service operator communicates with the person with a speech disability through a TTY (a telecommunications device for people with a hearing loss or have speech disabilities) and with the other person through the telephone. The operator, who is not an interpreter, voices the TTY message and the other person can respond by voice.

SUGGESTED BEHAVIORS

Be patient. Wait for the person to finish his or her thought rather than interrupting or finishing it for the person, unless that person expressly gives you permission to do so.

Do not pretend to understand when you do not. This will hinder communication, not enhance it.

Repeat back what you do understand so the other person may fill in or correct your understanding where needed.

Ask the person to rephrase the thought or spell out a particular word to facilitate your understanding.

If you are having difficulty understanding what the person is saying, let the person know. "I didn't understand that last part. Could you please repeat it?" "I'm having difficulty understanding. Perhaps you could write it down for me." "I'm not sure if I understood correctly. Did you say...?"

Allow the communication to take as much time as necessary. Hurrying through the interaction can make the situation worse.

If you continue to have difficulty, offer pen and paper if the person is physically able to write, but first ask the individual if this is acceptable.

Concentrate on the words the individual is saying rather than how they are being said.

If no solution to the communication barrier can be worked out between you and the individual, ask if there is someone who could facilitate the conversation.

TOURETTE

People with Tourette Syndrome

GENERAL INFORMATION

Tourette Syndrome is a neurological disorder with two basic features: involuntary motor tics and involuntary vocal tics. The symptoms come and go, vary in intensity, and change over time. Many individuals with Tourette Syndrome have Attention Deficit Disorder (i.e., difficulty with attention and impulse control) and Obsessive-Compulsive Disorder (i.e., controlling urges) and/or some form of learning disability.

Motor tics caused by Tourette Syndrome include eye blinking, shoulder shrugging, facial grimaces, and arm waving. Vocal tics include production of noises such as throat clearing, tongue clicking, and barking sounds, as well as vocalization of socially unacceptable words such as cursing and insulting comments.

Tourette Syndrome is exacerbated by both positive and negative stress, anxiety or worry. Therefore, the symptoms could be manifested differently or more repeatedly each day depending on the circumstances of that particular day. To reduce the symptoms, the individual is advised to rest or temporarily leave the stressful situation.

SUGGESTED BEHAVIORS

If someone is exhibiting the symptoms of Tourette Syndrome, it is best to ignore the symptoms.

If the symptom is bothersome or intrusive and cannot be ignored, bring it to the attention of the person in a non-judgmental and non-threatening way.

If the symptom is a physical one, move out of the way.

Do not react with anger or annoyance if the person displays motor or vocal tics.

Remember the person cannot control the tics and behaviors.

Be patient.

Several short breaks are often more effective than one long break.

It may help to allow the person to briefly go to a private place where the person is comfortable to relax and release tics. Short time-outs are very helpful.

VISION

People Who Are Blind or Have Low Vision

GENERAL INFORMATION

People who have congenital blindness have been without sight since early childhood or birth. People who have adventitious blindness lost their sight later in life often as a result of disease, aging, or a sudden injury. It is important to differentiate between these two conditions because of the diversity in education, employment, and attitudes among people with these two different types of blindness.

An individual who has congenital blindness most likely formed his or her identity as a person who is blind. People with congenital blindness probably received special education services throughout school and learned to use Braille and assistive devices at a young age.

Someone with adventitious blindness most likely formed his or her identity as a person who is sighted. When people lose their sight later in life, they often experience a period of tremendous shock. They need to learn the skills to help them adapt to a life without vision. Very often, these individuals do not know Braille.

The terms "blindness" and "low vision" mean either a complete or partial loss of vision. What a person is able to see depends upon the age of onset, degree of visual memory, and degree of usable vision regarding light, shape, color, and other factors. For some persons, only the edges or a part of the visual field might be obscured. Others might have no central vision although side or peripheral vision still exists.

Vision disabilities also include tunnel vision and color blindness. Tunnel vision has been described as seeing the world through a small tube. It is often accompanied by night blindness. This means that the person with tunnel vision may function very well in good light but not when the light gets below a certain level. The most common causes of tunnel vision are glaucoma and retinitis pigmentosa (RP). Color blindness describes a number of difficulties in identifying various colors and shades. The severity of the condition ranges from only a slight difficulty distinguishing among different shades of the same color to the rare inability to distinguish any colors.

"Low vision" generally refers to a severe vision disability, not necessarily limited to distance vision. Low vision applies to all individuals with sight who are unable to read the newspaper at a normal viewing distance, even with the aid of eyeglasses or contact lenses. This includes individuals who are legally blind.

There is a large range of behaviors that are common for some people who are blind. For example, a person who is blind may or may not look directly at you. An individual might rock back and forth or move his or her head around. In a room with a public address system, the person who is blind might face the nearest electronic speaker rather than the podium because that is from where he or she hears the voice of the person who is speaking.

Some people who are blind use an assist animal or cane to get around independently while others do not use these mobility aids.

SUGGESTED BEHAVIORS

Announce your presence by name because your voice may not be recognizable. When you leave a person's presence, say so.

Speak directly to the person in a normal speed and tone of voice. Shouting or speaking overly slow is not helpful.

When conversing with a group of people, identify the person to whom you are speaking. If a person who is blind or has low vision does not respond to you, it may be because he or she thinks you are talking to someone else.

In meetings, ask each person to identify himself or herself by name before they speak. Continue this until people's voices become familiar and recognizable.

Offer assistance in filling out forms, and be prepared to read aloud any information that is written, if requested. Many people with a vision disability can fill out forms and sign their names if the designated spaces are indicated to them.

When giving directions, use a relevant reference. "Two steps to your left" is a better way to describe a location than a vague expression such as, "over there." Some individuals like to refer to positions in terms of clock hands: "The chair is at your 2 o'clock."

Use directional words with the other person's orientation. For example, when you are facing someone, the door that is on your "left" is the same door that is on that person's "right."

If a person asks you for assistance in going from one location to another, put out your arm and tell him or her that your arm is there. He or she will then take your arm and you can proceed. Do not just grab the person's arm.

Walk at a comfortable pace when guiding a person who is blind. There is no need to walk slowly. Let the person know if you are approaching a step or other obstacle, and how you plan to navigate it.

When guiding a person into a new or strange surrounding, describe special features or physical characteristics of the area. When going into a room, orient the person to the surroundings: describe where furniture is, where the door is, and where the person is in relation to these objects.

When speaking to a person with low vision, position yourself so that the sun or any other bright lights are in front of, not behind, you. Your face will be illuminated and, at the same time, glare or blinding light in the eyes of the other person will be eliminated.

Petting or touching a dog guide or other service animal (usually indicated by a harness) while it is "on duty" is not appropriate. When the animal is not on duty, it is up to the animal's human to decide if play is permitted.

If you are offering a seat, physically indicate the back or arm of the chair or give a verbal cue as to the seat's location, e.g., "The chair is one step to your right" or "The chair is two steps behind you." Then the person will be able to sit down by him or herself. Neither force the person into the chair, nor move the chair without telling the person.

Be aware that the person may need to use a tape recorder or Braille device to note information.

When a person who has low vision is meeting many people, introduce each person individually. This helps the person to better associate names and voices for subsequent encounters.

Be precise and thorough when you describe people, places, or things. Use descriptive language. If the person has visual memories, references to colors, patterns, designs and shapes are perfectly acceptable. If not, try to attach other descriptive words and ideas to colors. For example, red is often associated with hot, blue with cool, green with calm, yellow with cheery.

Use alternative formats for written materials, such as Braille, large print, computer disk, and audio. Also, increase the frequency of oral announcements, provide audiotapes or Braille transcripts of frequently requested information, and read aloud brochures or important information.

Many people who are blind or have low vision are quite comfortable reading documents and messages from a computer utilizing a screen reader, magnification software, or other assistive technology, so electronic mail with or without text attachments is an excellent way to communicate on a regular basis.

When interviewing or meeting with people with vision disabilities, ask whether they would prefer a well-lit area. Avoid sharp contrasts of light and dark areas. Ask the employee whether he or she learns best from oral instruction or a combination of hands-on, written, and aural learning.

At a meeting, read and describe all information that is included in a visual presentation so that everyone understands it.

When preparing visual presentations, keep font sizes large and use contrasting colors to ensure ease in reading. You might also provide the materials in alternate formats.

AFTERWORD

This document is meant to provide a quick guide to facilitate communication and ease interactions between people with and without disabilities. It is an expansion and revision of a publication that was originally published in 1994 by the Equal Opportunity Programs Office at NASA's Goddard Space Flight Center. It had its roots in materials I originally developed for the inauguration of President Jimmy Carter in 1977 and expanded for the Office of the Assistant Secretary for Personnel Administration at the U.S. Department of Health and Human Services.

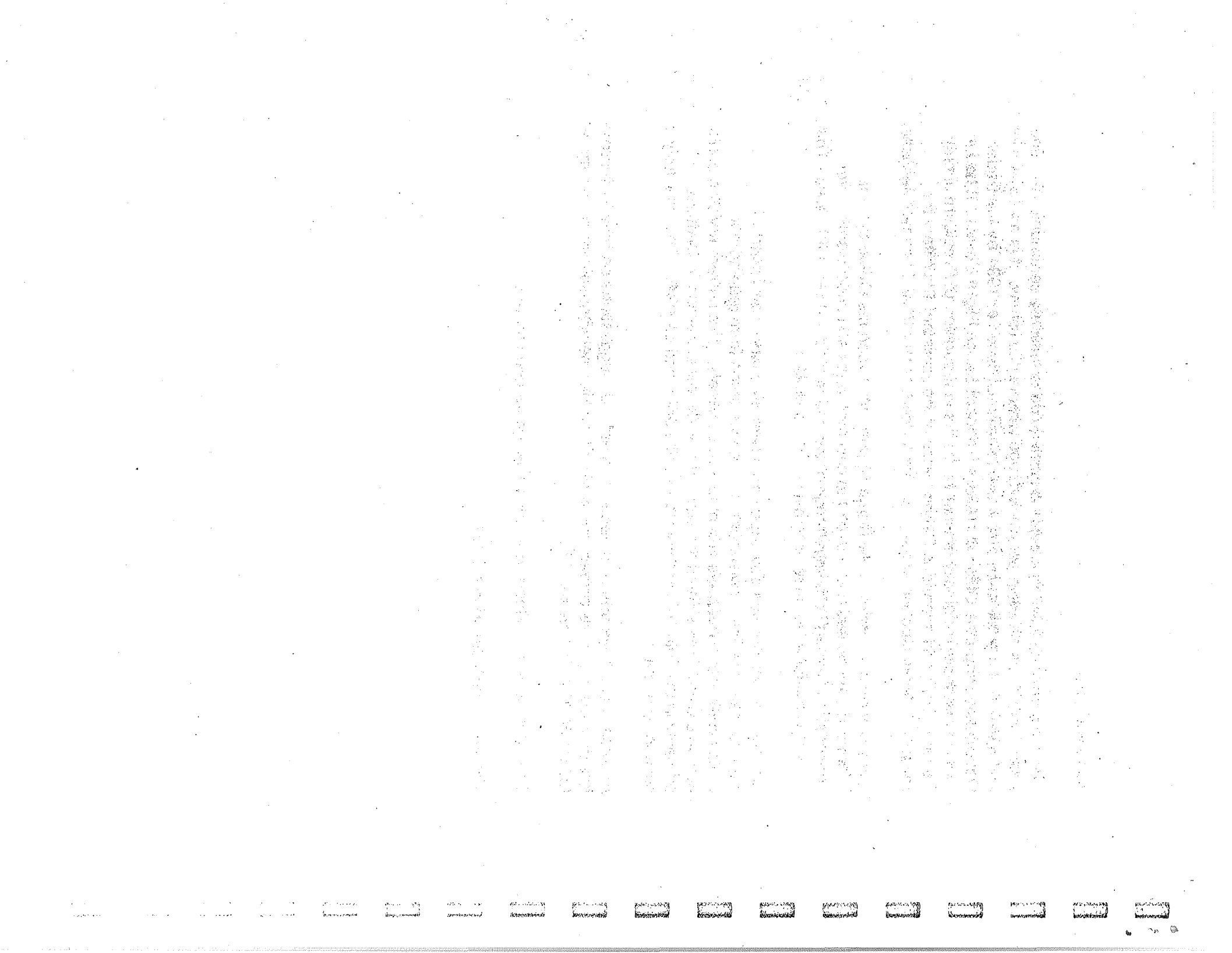
It is the hope and desire of the Equal Opportunity Programs Office that this information will be especially useful to new managers and supervisors. We cannot stress enough the importance of training and education in this area. This booklet is designed to augment training, not to replace it.

Most of the material was developed from over 30 years of professional experience in the field of disability. Some was taken from reading and discussions with colleagues and other professionals. This current revision could not have been done without the support and review of several individuals, primarily in the fields of communication, disability, and diversity. This was truly a collaborative effort.

As such, if you have any comments, concerns, or suggestions on how to improve this document, please contact me at Michael.J.Hartman@nasa.gov, or call me at (301) 286-5715, voice and TTY.

This document is available in an alternate format upon request.

Michael J. Hartman, March 2004



MSCOD
Minnesota State Council
On Disability

Minnesota State Council on Disability
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Summary of Services

We meet our charge by offering wide-ranging services. These include:

- Review and advise on disability issues to the governor, legislature and state agencies
- Research, collection and dissemination of relevant statistics
- Training on disability topics such as disability awareness, ADA and emergency evacuation
- Technical assistance on disability services and policies
- Consultation on programmatic and physical accessibility
- Advice on building code access

Our specialties include:

- Building accessibility
- Accessible housing
- Employment
- Rural transportation

Publications

Several publications and other communications keep our constituents informed.

The Building Access Survey, known as the "blue book," summarizes Minnesota's accessibility building code requirements.

Responding to Disability: "A Question of Attitude," a classroom favorite, is a straight-forward guide that helps teachers and others answer sensitive questions about people with disabilities.

Disability Parking, this brochure provides a comprehensive overview of the Minnesota Disability parking law.

The Americans with Disabilities Act, an overview of the five titles of the ADA.

Visit us at **www.disability.state.mn.us** for a complete guide to our many services. Features include links to related services, publication downloads and council meeting schedules and agendas.

Our **listserv** keeps you current with information and connects to others in the disability community. Email us at council.disability@state.mn.us to subscribe.

MSCOD
Minnesota State Council
On Disability

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ADVANCING THE RIGHTS OF MINNESOTANS WITH DISABILITIES

MSCOD is the comprehensive disability resource for lawmakers, agencies, non-profits, businesses and individuals with disabilities.

MSCOD
Minnesota State Council
On Disability

Your technical assistance & training resource.

Call on the Comprehensive Resource

The Minnesota State Council on Disability advances the rights of Minnesotans with disabilities.

Call on us if you write the law, need to follow it, need to know your rights or need to know about the resources available to you.

Serving a Broad Mission

Our broad charge touches the lives of virtually every Minnesotan.

For our constituents, we are the resource making good policy for people with disabilities. That's why the governor's office and legislature can count on us to provide technical assistance, research and recommendations throughout the lawmaking process.

Our contributions extend to the rest of state government, too. In addition to making our resources available, we collaborate with state departments and agencies that serve people who are blind and visually impaired, deaf and hard of hearing, those having developmental disabilities or mental illnesses, and those needing assisted technology.

Reaching Beyond Government

Our expertise also helps many in the private sector meet the needs of people with disabilities. We're available to assist employers, as well as administrators of disability programs, services and facilities.

Reaching Out to People with Disabilities

We have handled just about any disability-related issue you can imagine.

As a resource to individuals with disabilities and their families, our major areas of emphasis include housing, employment, accessibility and rural transportation.

Mission Statement

The Minnesota State Council on Disability is an agency that advises, provides technical assistance, collaborates and advocates to expand opportunities, improve the quality of life and empower all persons with disabilities.

About MSCOD

The state legislature created the council in 1973 to supplement the efforts of other advocacy groups.

Each of the council's 21 members is appointed by the governor and either has a disability, has a family member with a disability or works with people with disabilities.

Ongoing Activities

MSCOD enhances its role as a resource by overseeing a variety of ongoing activities.

This includes the **Disability Legislative Forum,** a statewide interactive video conference which gives voice to more than 150 organizations by linking to Greater Minnesota communities.

We take our message to the community through **Disability Awareness Month activities,** the **ADA celebration,** the **Minnesota State Fair** and an **awards recognition program.**

MSCOD
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On Disability

To request this brochure in an alternate format (Braille, large print or audio cassette), or to be added to our mailing list, you may call, email or complete and mail the following form.

Name: _____

Title: _____

Agency: _____

Address: _____

City: _____

State: _____ ZIP: _____

Daytime phone: _____

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Please add me to your mailing list.

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- ☐ No

Please add me to your listserv.

- ☐ Yes
- ☐ No

I am a:

- ☐ Person with a disability
- ☐ Family member of a person with a disability
- ☐ Employer
- ☐ Student
- ☐ Other _____