Determination of Eligibility for Michigan Mandatory Special Education for Infants and Toddlers, Birth to Age Three
Autism Spectrum Disorder Guidance

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Determination of Eligibility for Michigan Mandatory Special Education for Infants and Toddlers, Birth to Age Three Autism Spectrum Disorder Guidance

Purpose

The purpose of this document is to provide guidance for the determination of Michigan Mandatory Special Education (MMSE) eligibility for infants and toddlers, birth to age three, exhibiting Autism Spectrum Disorder (ASD) as defined by the Michigan Administrative Rules for Special Education (MARSE).

Persons who will be able to utilize this guidance include:

- Part C personnel (including special education personnel) considering a referral of an infant or toddler.
- Multidisciplinary evaluation team members, including parent or guardian.
- Individualized Family Service Plan (IFSP) team members, including parent or guardian.
- Administrators.

This document serves to clarify the eligibility process to ensure:

- Consistent practice among school districts within and across counties.
- Compliance with Michigan special education law and administrative rules.
- Implementation of best practices.
- Appropriate determination of eligibility within this category.

Acronyms

ABA – Applied Behavior Analysis

IDEA – The Individuals with Disabilities Education Act

IFSP – Individualized Family Service Plan

ISD – Intermediate School District

LEA – Local Education Agency

MARSE – Michigan Administrative Rules for Special Education

MET – Multidisciplinary Evaluation Team

MMSE – Michigan Mandatory Special Education

OSEP – Office of Special Education Programs at the US Department of Education

START – Statewide Autism Resources and Training

Applicable Regulations

Individuals with Disabilities Education Act (IDEA), Part C, 34 CFR §303 (2011)

§ 303.21 Infant or toddler with a disability.

(a) Infant or toddler with a disability means an individual under three years of age who needs early intervention services because the individual—

(1) Is experiencing a developmental delay, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:
   (i) Cognitive development
   (ii) (Physical development, including vision and hearing
   (iii) Communication development
   (iv) Social or emotional development
   (v) Adaptive development

(2) Has a diagnosed physical or mental condition that—
   (i) Has a high probability of resulting in developmental delay, and
   (ii) Includes conditions such as chromosomal abnormalities, genetic or congenital disorders, sensory impairments, inborn errors of metabolism, disorders reflecting disturbance of the development of the nervous system, congenital infections, severe attachment disorders, and disorders secondary to exposure to toxic substances, including fetal alcohol syndrome.

§ 303.321 Evaluation of the child and assessment of the child and family.

(a) *General*.

(1) The lead agency must ensure that, subject to obtaining parental consent in accordance with § 303.420(a)(2), each child under the age of three who is referred for evaluation or early intervention services under this part and suspected of having a disability, receives –
   (i) A timely, comprehensive, multidisciplinary evaluation of the child in accordance with paragraph (b) of this section unless eligibility is established under paragraph (a)(3)(i) of this section; and
   (ii) If the child is determined eligible as an infant or toddler with a disability as defined in § 303.21—
      (A) A multidisciplinary assessment of the unique strengths and needs of that infant or toddler and the identification of services appropriate to meet those needs;
      (B) A family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and

services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler. The assessments of the child and family are described in paragraph (c) of this section and these assessments may occur simultaneously with the evaluation, provided that the requirements of paragraph (b) of this section are met.

Michigan Administrative Rules for Special Education (MARSE) (October 2015)

R 340.1701(b) Multidisciplinary evaluation team

"Multidisciplinary evaluation team" means a minimum of two persons who are responsible for evaluating a student suspected of having a disability. The team shall include at least one special education teacher or other specialist who has knowledge of the suspected disability.

R 340.1715 Autism spectrum disorder defined; determination

(1) Autism spectrum disorder is considered a lifelong developmental disability that adversely affects a student's educational performance in 1 or more of the following performance areas:
   (a) Academic.
   (b) Behavioral.
   (c) Social.

   Autism spectrum disorder is typically manifested before 36 months of age. A child who first manifests the characteristics after age 3 may also meet criteria. Autism spectrum disorder is characterized by qualitative impairments in reciprocal social interactions, qualitative impairments in communication, and restricted range of interests/repetitive behavior.

(2) Determination for eligibility shall include all of the following:
   (a) Qualitative impairments in reciprocal social interactions including at least 2 of the following areas:
      (i) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
      (ii) Failure to develop peer relationships appropriate to developmental level.
      (iii) Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people, for example, by a lack of showing, bringing, or pointing out objects of interest.
      (iv) Marked impairment in the areas of social or emotional reciprocity.

(b) Qualitative impairments in communication including at least 1 of the following:
  (i) Delay in, or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime.
  (ii) Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others.
  (iii) Stereotyped and repetitive use of language or idiosyncratic language.
  (iv) Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

(c) Restricted, repetitive, and stereotyped behaviors including at least 1 of the following:
  (i) Encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
  (ii) Apparently inflexible adherence to specific, nonfunctional routines or rituals.
  (iii) Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements.
  (iv) Persistent preoccupation with parts of objects.

(3) Determination may include unusual or inconsistent response to sensory stimuli, in combination with subdivisions (a), (b), and (c) of sub-rule 2 of this rule.

(4) While autism spectrum disorder may exist concurrently with other diagnoses or areas of disability, to be eligible under this rule, there shall not be a primary diagnosis of schizophrenia or emotional impairment.

(5) A determination of impairment shall be based upon a comprehensive evaluation by a multidisciplinary evaluation team including, at a minimum, a psychologist or psychiatrist, an authorized provider of speech and language under R 340.1745(d), and a school social worker.

R 340.1862 Individualized family service plan; timelines; eligibility. Rule 162.

(1) Eligibility for Michigan special education services for all children with a disability birth to age three shall be determined by and documented in an individualized family service plan.

(2) Evaluations conducted to determine eligibility for Michigan special education services shall meet the requirements of 34 CFR part 303 and R 340.1705 to R 340.1717.

(3) Determination of eligibility for Michigan special education services, for a child birth to three with a disability shall follow all timelines and requirements pursuant to 34 CFR part 303.

(4) Special education services for children birth to three with disabilities shall be all of the following:
    (a) Determined by the child's individual needs and specified in an individualized family service plan.
    (b) Provided by an approved or endorsed early childhood special education teacher or approved related services staff.
    (c) Provided for not less than 72 clock hours over one year. The time line begins upon receipt of signed parental consent to provide services.
    (d) Provided in an appropriate early childhood setting, school setting, community setting, or family setting.
    (e) Have a parent participation and education component.
(5) Approved related services staff shall work under the educational direction of an approved or endorsed early childhood special education teacher.

Considerations

Educational Performance

Rule 340.1715 defines autism spectrum disorder as a disability that adversely affects educational performance. Because infants and toddlers are not typically in a school-based setting, examining how a child functions within his/her daily routines, while taking into consideration his/her family's culture, is necessary.

IDEA regulation 34 CFR §300.304 clarifies that progress in the general curriculum for a preschool child is participation in age appropriate activities. Therefore, "**functional performance**" for infants and toddlers is the equivalent of "educational performance" for school-age children. Determining if the child's disability affects his/her ability to fully participate within his/her daily activities is factored into determining how the ASD adversely affects functional performance. The adverse effect should be referenced in relationship to same-age peers.

Lifelong Developmental Disability

The MARSE definition states that "Autism Spectrum Disorder is considered a lifelong developmental disability." The reference to "lifelong" is intended to indicate that this impairment is typically identified before 36 months of age, and is a disorder that is a lifelong condition. As with any developmental disability, it is important to distinguish between having an autism spectrum disorder and the impact of the impairment on participation in age appropriate activities. For this reason, the MARSE definition of a "student with a disability" requires that the IFSP team determine two things: first, that the infant or toddler has an impairment, and second that the impact of the impairment necessitates special education and/or related services.

While an infant or toddler may meet eligibility requirements when evaluated, it is difficult to know the lifelong impact of any impairment, especially given the rapid developmental changes in early childhood. For this reason, IFSP's must be reviewed at least every six months. Evaluators should avoid overemphasizing "lifelong" in initial evaluations. While the **condition is lifelong, adverse impacts may not require special education for an entire school career**.

Evaluators are encouraged to focus on the infant or toddler's current functioning and the preponderance of evidence demonstrating that the infant or toddler currently meets MARSE ASD eligibility criteria. As children grow and mature, IFSP teams may look at other eligibility categories, and at any time, with new data, the IFSP team may revisit and change the eligibility category. Identification under the ASD criteria indicates that the infant or toddler is **currently** eligible under ASD.

Regardless of the infant or toddler's MMSE eligibility, the category does not dictate the program or services. Rather, services are driven by the IFSP team's data-based determination of the individual needs of the infant or toddler in question.

Determining Eligibility for ASD

As it is with all eligibility areas, special education eligibility for ASD is a three-pronged process:

1. Infants and toddlers must meet the MARSE **eligibility criteria** for ASD;
2. The ASD must **adversely affect** the infant or toddler's functional performance in one or more of the following areas:
    a. Academics/Pre-Academic (e.g. functional performance in such age-appropriate activities as communication, engagement in routines, emerging readiness skills, social engagement)
    b. Behavior
    c. Social Domains, and
3. The impact must **necessitate special education** and/or related services.

Evaluation

Evaluation is the procedure used by qualified personnel to determine a child's initial and continuing eligibility (34 CFR §303.321). A multidisciplinary evaluation team, consisting of a minimum of two persons, is responsible for completing a full and individual evaluation when a child is suspected of having a disability (R 340.1701b).

Team Members

Prior to beginning the evaluation process, a multidisciplinary evaluation team (MET) must be established. The members of the MET should align with all areas of suspected disability. Minimally MARSE requires that the required team members for ASD evaluation must include:

- Speech and Language Pathologist
- School Psychologist or Psychiatrist
- School Social Worker

Professional Expertise

Professional expertise is an important factor in assessing the skills of infants and toddlers. Team members should possess the following skills:

- Expertise in the variability and rate of **typical development** for infants and toddlers
- Understanding of the **key indicators** of autism spectrum disorder as they present with infants and toddlers
- Informed clinical understanding of **marked** and **qualitative differences**.

Note: See *Practice Tips* embedded throughout this guidance and Appendix A: *ASD Eligibility Guidance Chart for Infants and Toddlers* which provides examples of typical and marked atypical development Eligibility Criteria for ASD.

To meet the MARSE eligibility criteria for ASD, infants and toddlers must demonstrate characteristics in **all three** of the following domains:

1. Qualitative impairments in reciprocal social interactions
2. Qualitative impairments in communication
3. A restricted range of interests or repetitive behavior

Two additional factors may be considered in determining eligibility under the ASD criteria:

- Unusual or inconsistent response to stimuli
- Age

Qualitative impairment is defined as atypical or considerably different from other infants and toddlers the same age, as opposed to a mere delay in development. It is evident across multiple environments and social partners.

A review of the three domains within the ASD rule (R 340.1715) is provided below, along with *Practice Tips* that include examples of atypical behavioral characteristics for infants and toddlers within each domain. Appendix A gives additional information regarding typical and atypical development as well as guidance for differential decision-making.

Domain #1: (2)(a) Qualitative Impairments in Reciprocal Social Interactions

The MARSE defines a qualitative impairment in reciprocal social interactions to require the presence of at least two of the following four areas:

Area (i): Marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.

Marked impairment in this area means substantial and sustained difficulty in the quality and functionality of nonverbal behaviors to augment communication with a social partner. This criterion is not intended to define the presence or absence of nonverbal behavior but rather the use of nonverbal behavior to regulate social communication, particularly where words fail. Marked impairment also implies that the difficulties are clear and observed across multiple environments and people over time.

Practice Tip: Evidence of marked impairment in nonverbal behaviors in infants and toddlers may include, but is not limited to:

Eye-to-Eye Gaze

- Differences in eye-to-eye gaze (e.g., seems to look "through" a person, limited or no eye contact or eye gaze to initiate, sustain, or guide social interaction, has fleeting or inconsistent eye contact).
- Observing eye-to-eye gaze: During a standardized assessment, an infant or toddler may have limited eye contact and frequently look at the novel items presented to him or her. However, when the infant or toddler does look at adults, it is important to note whether eye contact is used as a tool to continue the social interaction. For example, if an adult rolls a ball to the infant or toddler and the infant or toddler rolls the ball back to the adult and looks at the adult in anticipation of the ball being rolled back, the infant or toddler is using eye gaze to sustain social interaction.

Note: Consideration should also be given to the cultural expectations regarding eye contact for an infant or toddler.

Facial Expression

Differences in the infant or toddler's facial expression matching events in the environment or the infant or toddler's use of facial expressions as a way of communicating (e.g., lacks emotion or appropriate facial affect for the social situation, lacks accurate facial expression to reflect internal feelings, facial expressions seem rehearsed or mechanical, limited or no use of facial expression to guide communication)

Body Postures

Differences in body posture (e.g., difficulty maintaining appropriate body space, awkward/stiff response or movement)

Gestures

- Differences in spontaneous use of gestures that indicate a lack of understanding of the use of nonverbal cues (e.g., pointing, head nod, head shake, waving)
- Does not respond to a communication partner's signals to start or end a conversation
- Differences in the nonverbal behaviors that infants and toddlers typically use to regulate social interactions. Typical nonverbal behaviors include: reaching up to be picked up, reaching and/or pointing to people and objects, shaking their head to indicate "no", nodding to indicate "yes", waving hi/bye, giving "High 5's", blowing a kiss, engaging in social smile
- Differences in the infant or toddler's understanding of the nonverbal gestures and expressions of others

Area (ii): Failure to develop peer relationships appropriate to developmental level

The phrasing of this characteristic is extremely important because it acknowledges incremental developmental stages in peer–to–peer social reciprocity. Therefore, evaluators should be keenly aware of these stages of development.

For example, by age three, the parallel play that is characteristic of the interaction of the two-year-old is replaced with social play with peers. This can center on shared interests, rough and tumble play, as well as complicated schemes. Consideration of typical social development should be included in determining social impairment in young children.

Since this characteristic is one of four intended to be a manifestation of a qualitative impairment in reciprocal interactions, the evaluator should be sensitive to alternative explanations for a perceived "failure to develop peer relationships appropriate to developmental level", such as a lack of opportunity to engage in peer interaction, cultural factors, and possible cognitive impairment.

Practice Tip:

Indicators of Emerging Social Reciprocity Development

- Differentiate between immature play compared to lack of social interactions during play (an infant or toddler can be at the stage of mouthing items and still socially seek out interactions with peers)
- Describe how the infant or toddler imitates other children
- Describe the infant or toddler's interest and/or attempt to interact with peers, as this may demonstrate the desire to engage with others

Contra-indicators of Emerging Social Reciprocity Development

- Disruption of ongoing activities when entering play or social circles; may insist on controlling the play when engaging with others
- Lack of initiation or sustained interactions with seemingly no awareness or concern for the distress of others
- Preference to play alone
- Misinterpretation of social cues or communication intent of others
- Tolerance of peers but no spontaneous engagement in conversation or activity

Area (iii): Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., a lack of showing, bringing, or pointing out objects of interest).

Marked impairment in this area means substantial lack of spontaneous (i.e., without prompting) sharing and showing, often referred to as, "joint attention". According to Oates & Grayson (2004), joint attention is defined as, "the shared focus or experience of two or more individuals on an object or activity". This typically begins to develop around two months of age with dyadic (two person) exchanges using looks, noises, and mouth movements. Lack of sharing with others results from deficits in understanding the perspectives of others.

Marked impairment in this area should be clear across multiple people and environments over time.

Practice Tip:

Observational data on **spontaneous seeking to share** may include, but is not limited to, the following:

- How does the infant or toddler draw the attention of others to his or her completed tasks?
- How does the infant or toddler attempt to initiate social interaction?
- How does the infant or toddler socially direct their smile or smile in response to another person's smile or in response to praise?
- How does the infant or toddler point out objects of interest to share the enjoyment with others?
- When observing, look for joint attention and if necessary create some opportunities to observe interactions between the infant or toddler and others in the natural environment. Joint attention includes: an infant or toddler sees an item/event, and then looks to the other person to see if partner is looking at the same item/event and then looks back at the item/event (i.e., 3-point gaze). They are sharing the experience.

Evidence of impairment in spontaneous seeking to share would include, but not be limited to:

- Deficits in the use of pointing for orienting to another, or to an object or event
- Limited number of attempts to share achievements or items of interest with others as compared to peers
- Brings objects or items to others for the purposes of getting needs met, but not for a shared experience
- Lacks response to others sharing enjoyment, interests, or achievements (e.g., shifting conversations to one's own interest rather than responding to the interests of others)
- Lacks warm, joyful engagement (e.g., smiling/laughing during activity)
- Has difficulty with social referencing (i.e., shifting from faces to objects and back to faces) despite looking at faces as much as typically developing children.

Area (iv): Marked impairment in the areas of social or emotional reciprocity.

Reciprocity is defined as the mutual give-and-take of social interactions and refers to how the behavior of one person influences and is influenced by the behavior of another person and vice versa.

Marked impairment in this area means significant difficulty recognizing and responding to the needs, intentions, perspectives, and feelings of others across multiple environments and people over time.

Practice Tip:

Evidence of social or emotional reciprocity:

Emotional reciprocity is defined as back and forth flow of emotional expression. In infants and toddlers, emotional reciprocity is seen with mutual affective behaviors such as smiles, laughter, and grimaces. Infants and toddlers learn to imitate behaviors such as sticking their tongue out, clapping and cheering for themselves, and their accomplishments.

In infants and toddlers under the age of three, examples of social and emotional reciprocity may include imitation, turn taking, experience sharing.

Evidence of impairment in social or emotional reciprocity may include, but is not limited to, the following:

- Differences in social interaction; including play, reciprocity and shared enjoyment, as compared to the infant or toddler's developmental level, based on observation in the child's natural environment, and the child's opportunities to learn/experience these skills.

- Highly unusual and persistent attachment to objects (as opposed to people) to help soothe emotionally.
- Limited or lack of participation or enjoyment in back and forth social games or play routines (patty cake, peek-a-boo and finger play, Itsy Bitsy Spider)
- Limited to no use of social smiling in response to others; rarely offers spontaneous social smiles in response to others
- Lacks interest in the ideas of others
- Aloofness and indifference toward others
- Fails to understand how their behavior impacts how others think or feel
- Problems with social conventions (e.g., turn-taking, politeness, social space)
- Lacks appropriate response to someone else's pain or distress (e.g., laughing when others are upset)
- Lacks response to name

Alternative Explanations for Reciprocity Deficits

- Social interactions like other behaviors can be influenced by the infant or toddler's history of reinforcement. An infant or toddler raised in an environment that is not rich in reinforcement of social interactions, such as eye contact or pointing out items of interest, may not be as likely to display those behaviors.
- Infants and toddlers exposed to trauma may show deficits in social interactions that mirror characteristics of autism.
- It is important to differentiate between an infant or toddler who is shy with strangers, and an infant or toddler who does not display the above behaviors with familiar adults. Due to the nature of evaluation of children under three, every attempt should be made to collect data on the presence or absence of these behaviors in natural routine-based interactions with familiar adults or peers.
- Chronological age, developmental level and the infant or toddler's opportunity to learn or experience these skills should always be considered when determining if a marked impairment exists.

Domain #2: (2)(b) Qualitative Impairments in Communication

A qualitative impairment is defined as atypical development or considerable differences, versus a mere delay in development. According to the MARSE, qualitative impairments in communication include **at least one** of the following:

Area (i): Delay in or total lack of the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime.

Typical development of language includes babbling by 12 months, single word use by 16 months, and two-word phrases by 24 months of age. Some infants or

toddlers fail to develop language yet compensate by using alternative communication modes such as gestures, facial expressions, and other nonverbal behaviors.

Some infants or toddlers with ASD, however, do not seem to recognize that words have a communicative intent. As such, they fail to compensate for their lack of language development, although they may ensure their needs get met (e.g., using an adult as a tool to get a snack or toy, or shoving someone to get them out of the way).

For infants and toddlers, often communication is nonverbal in nature and the measure of an infant or toddler's communication is an evaluation of the infant or toddler's language skills compared to his/her developmental level, as well as evaluating the child's attempts to communicate through nonverbal or alternative means. When lack of verbal communication is observed, it is critical to look at the infant or toddler's pre-verbal communication/sequence of development (e.g., sounds to illicit attention, pausing with another who is speaking) before concluding this criterion is met.

Practice Tip:

In some instances, infants or toddlers with ASD may begin to develop spoken language and then lose their acquired language.

Evidence of delay in or lack of the development of spoken language not accompanied by attempts to compensate may include, but is not limited to, the following:

- Pulls an adult to a particular area to get a snack or toy
- Stands or screams near the refrigerator in the absence of an adult
- Uses words for self-stimulation or predictability versus interacting with others (e.g., echolalia, jargon, gibberish, mumbling). **Note:** Evaluators are encouraged to note the infant or toddler's ability to use any manner of communication in a functional/purposeful way to differentiate between word/sound production versus communicative intent.
- Engages in challenging behavior in lieu of alternate communication (e.g., hitting, biting, pushing, screaming)

Area (ii): Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others.

Pragmatics refers to the way a child uses language in social situations, both to respond to communication from others and to initiate and sustain interaction with others. Deficits in pragmatics for infants and toddlers with ASD result from deficits in understanding the perspectives of others and lack of social reciprocity.

Practice Tip: Evidence of pragmatics for infants and toddlers include:

- Brings an object to an adult or holds it out to show it to them
- Tries to gain attention by using sounds, eye gaze, gestures, words
- Requests things by using sounds, eye gaze, gestures, words
- Attends to and responds to the facial expressions, sounds, gestures, and words of others
- Comments on an object or action by getting the adults' attention, pointing, vocalizing, or saying a word
- Looks at a speaker or responds with facial expressions, vocalizations, gestures, or words when someone speaks
- Uses words, short phrases, or sentences for a variety of language purposes: greeting, getting attention, protesting, commenting, giving directions, asking questions
- Engages in verbal turn-taking and conversations

Because pragmatic language becomes more complex as children get older and may be difficult to assess in infants and toddlers, particularly those who are not yet using words, attention should be paid to the way in which a child uses nonverbal communication to initiate interaction and respond to others in social situations.

Area (iii): Stereotyped and repetitive use of language or idiosyncratic language.

Infants and toddlers with ASD may exhibit stereotypical (e.g., use of nonsense words or phrases or verbal fascinations) and repetitive or idiosyncratic language (e.g., contextually irrelevant or not understandable to the listener due to a private meaning).

The key to evaluating for this characteristic is not just identifying the presence of stereotypical, repetitive or idiosyncratic language, **but also** identifying the absence of an associated functional/purposeful/relationship based communicative use of such language.

Practice Tip: Evidence of stereotyped, repetitive, or idiosyncratic language may include, but is not limited to, the following:

- Repeats words or phrases over and over
- Repeats what others say (echolalia) either immediately after the person said it or at some time in the future
- Repeats television or movie lines, song lyrics, or other media that are out of context and add no meaning to the conversation
- Uses words with a private meaning that only makes sense to those who are familiar with the situation where the phrase originated (e.g., every time the toddler enters the room he states, "That's right on the money!", or repeating the news slogan, "First at four!")

Area (iv): Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

Spontaneous make-believe play is a precursor to the use of symbols and corresponds with language development. Social imitative play is also thought to be an early sign of social reciprocity.

Play schemes and make believe are developmental and may be limited in infants and toddlers. When assessing play skills, evaluators are encouraged to pay attention to the infant or toddler's ability to begin varying and/or expanding on schemes.

Practice Tip: Observation during play with others is highly recommended whenever possible when conducting infant and toddler evaluations for ASD. The following are guidelines regarding the **typical developmental** sequence of play to consider:

- Object exploration—Explores an object, but does not assimilate how to use it in play (e.g., makes stirring motion with a spoon and then drops it)
- As young as 16 months, directs play towards another person (e.g., picks up the pretend cell phone, makes a ringing sound, and hands it to a parent)
- Representational play—Uses "meaningless" objects in a creative way to play a role in pretend play (e.g., block becomes a cell phone or a train)
- Parallel play—Between the ages of 18 months and three years, plays next to, but not with, other infants and toddlers; may not appear to interact with, but is very aware of, the presence of other infants and toddlers
- Around age three, play moves from objects to imaginary objects or beings (e.g., swing becomes a spaceship, cup contains pretend tea)
- Also, around age three, begins to animate toys (pretends to feed a doll that is hungry)

Evidence of the lack of these behaviors may include, but is not limited to, the following:

- Lacks imitation or make-believe play
- Fails to move beyond repetitive play to symbolic play
- Lacks spontaneous pretend play with toys (e.g., uses objects only as they are intended)
- Shows little elaboration on learned play schemes
- Lines up toys like cars or trains, stuffed animals, or action figures
- **Note:** Because this may be a step in the development of play, it is important to understand the infant or toddler's developmental level. A focus should be the child's flexibility for when the sequence is interrupted or if the infant or toddler continues to interact socially while playing with the toys (e.g., child

can line up cars and pretend they are a parking lot but not have the language to express it). The red flag is evident when the toddler lines up items and doesn't let others expand on the play scheme.
- Focuses on only a part of the toy rather than actually playing with it (e.g., wheels on a toy car or train, the string of a pull toy) or focusing on the movement of the toy rather than the purpose of the toy (e.g., stacking blocks but not building anything)
- Lacks finger play (e.g., "Itsy Bitsy Spider") imitation without specific teaching and prompts or generalizing to other imitation in play
- Has limited play repertoires compared to peers (e.g., only plays with one specific toy or item)
- Lacks advancement of play repertoires over time
- Directs others to their assigned role in play rather than playing
- Engages in construction play (e.g., puzzles, building blocks, assembling Transformers, LEGO® bricks, setting up elaborate train track layouts) at the exclusion of flexible representational play

Alternative Explanations for Make-believe or Social-imitative Play Deficits

- Obtain contextual information to assist in differentiating between ASD-related play deficits, and alternative causes, (e.g., environmental issues, lack of opportunity to learn play skills). To rule out lack of opportunity to learn play skills, the evaluator may set up experience(s) to see how the infant or toddler responds to direct instruction in play.

Domain #3: (2)(c) Restricted, Repetitive, and Stereotyped Behaviors

Infants and toddlers with ASD engage in restricted, repetitive, and stereotyped behaviors that are extreme and often interfere with other more appropriate behaviors or daily life. Because infants and toddlers with ASD are driven to engage in these behaviors, they are difficult to stop or control. Disrupting the behaviors often causes significant distress for the child.

When compared to typically developing infants or toddlers, those with ASD have a significantly higher rate and inventory of repetitive movement with objects (e.g., collecting, spinning, rolling, lining, stacking) and repetitive movements of his/her body (e.g., flapping, rubbing, patting/tapping, stiffening fingers).

When compared to infants or toddlers with global developmental delays, infants or toddlers with ASD have a significantly higher rate and inventory of repetitive movement with objects, but not with repetitive movements of his/her body.

According to the MARSE, restricted, repetitive, and stereotyped behaviors must include ***at least one*** of the following:

Area (i): Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

Infants and toddlers with ASD can display intense interests and preoccupations that are intrusive, recur frequently, and interfere with participation in daily activities. Limited access, interruption, or removal of the activity or interest often causes significant distress. For infants and toddlers, repetitive behaviors or restrictive scopes of interest are developmentally typical. The noteworthy characteristic is that the behaviors and/or interests become dominant across environments ***and*** interfere with engagement. The degree to which behaviors are, or become **persistent** and **encompassing**, are key considerations in the evaluation process. In other words, the behavior(s) of concern would be present across settings and situations, not just with some people or in some situations.

Evaluators are encouraged to pay attention to the intensity and focus of the behavior and if the behavior interferes with functioning.

Practice Tip: Evidence of preoccupations and interests that are abnormal in intensity or focus may include, but is not limited to, the following:

- Talks about a particular topic (e.g., Bubble Guppies®) incessantly without regard to the conversational partner
- "Plays" with the same toy repeatedly and in the same way each time, beyond the typical development of play
- Uses a specific video game, television show, or movie as the lens through which experiences or the world are viewed
- Excessively seeks access to, or talks about, atypical interests (e.g., specific appliances), or unusual types of animals (e.g., white Siberian tiger)
- Intensity of interest significantly interferes with daily routines of the family (e.g., infant or toddler with interest in trains; screams in car until parent drives over railroad tracks; family leaves infant or toddler's LEGO® structure in front of TV and the family views the TV around the structure; infant or toddler insists on looking at every EXIT sign in buildings that are entered)

Area (ii): Apparently inflexible adherence to specific, nonfunctional routines or rituals.

Infants and toddlers with ASD seek predictability in their environment and thus may create and follow nonfunctional routines or rituals or have extreme distress when their routines are altered.

For infants and toddlers, challenges with transitioning between activities are developmentally to be expected. Evaluators are encouraged to pay more attention to an infant or toddler's insistence on nonfunctional routines, which when disrupted, results in distress.

Practice Tip: Evidence of inflexible adherence to nonfunctional routines or rituals may include, but is not limited to, the following:

- Wears a specific clothing item for a specific day or activity
- Rigidly adheres to specific self-imposed sequences in routines (e.g., must eat food or put clothes on in a specific order)
- Engages in excessive and time-consuming routines (e.g., bathroom, dressing)
- Displays distress when daily routines and schedules are altered
- Alphabetizes or sequences objects or people (e.g., knowing people by make and model of their car, alphabetizing their videos)
- Insistence that others follow rules, including rules made up by the infant or toddler (e.g., family members must sit in the same seat for meals)

Area (iii): Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements.

Some infants and toddlers with ASD engage in repetitive motor mannerisms, often called self-stimulatory behaviors.

Practice Tip: Typically developing infants and toddlers may exhibit self-stimulatory behaviors. These behaviors should be considered when they are clearly different from those of typically developing peers in terms of the intensity, frequency, duration or the context in which these behaviors occur. Evidence of stereotyped and repetitive motor mannerisms may include, but are not limited to, the following:

- Has preoccupation with fingers, spinning, and twirling objects or self
- Paces in a particular manner or routine
- Smells, chews, or rubs objects in a particular manner
- Rocks or lunges
- Persistently grinds teeth
- Visually inspects objects repeatedly, which may be from an unusual angle
- Engages in self-injurious behaviors including head-banging, hand biting, and excessive self-rubbing and scratching
- Stiffens the body repeatedly while opening and closing hands
- Displays distress when self-stimulatory behaviors are interrupted or altered.

Area (iv) Persistent preoccupation with parts of objects.

Infants and toddlers with ASD can become preoccupied with parts, objects, or processes. The fixation may appear to be more focused on how an object (like a toy) works instead of the function that it serves.

Practice Tip: Evidence of persistent (i.e. occurring over a prolonged period of time) preoccupation with parts of objects may include, but is not limited to, the following:

- Demonstrates a fascination with a specific part of the dishwasher or vacuum cleaner
- Spins the wheels of a car
- Watches several seconds of a movie or cartoon over and over again, without watching the complete movie, outside of typical development and in the absence of shared enjoyment with a parent or caregiver
- Completes complex puzzles with more interest in how the pieces fit together than the puzzle picture as whole

Additional Factor: Unusual or Inconsistent Response to Sensory Stimuli

Infants and toddlers with ASD may seek or avoid certain sensory stimuli to a degree that it interferes with daily activities. Specific sensory areas can include sight, touch, hearing, smell, taste, and movement.

According to MARSE, determination of ASD may include unusual or inconsistent responses to sensory stimuli, but to be eligible under ASD, the infant or toddler must also meet the other three domains of eligibility. Sensory challenges alone are not sufficient indicators of ASD criteria, because sensory issues can be found in other eligibility areas. Conversely, the absence of sensory challenges does not exclude an infant or toddler from meeting ASD eligibility criteria. The evaluation team should analyze the infant or toddler's response to sensory stimuli as it impacts the three domains of ASD eligibility (i.e., reciprocal social interaction, communication, and restrictive and repetitive behaviors).

Additional Factor: Age

According to MARSE, ASD typically manifests before 36 months of age. An infant or toddler may exhibit the characteristics after age three but generally the infant or toddler should have indicators of developmental differences by 36 months of age.

Adverse Impact

According to the MARSE, to be eligible for special education programs and services, an infant or toddler's disability (i.e., ASD) must also adversely affect functional performance in academic, behavioral, or social domains, to the point that the impact necessitates specialized instruction.

For an infant or toddler, functional performance is defined as performance in age-appropriate activities such as communication, engagement in routines, emerging readiness skills and/or social engagement. While educational performance is divided

into three separate areas, the impact of ASD is often holistic, with delays and differences in one area influencing another.

When determining if a behavior impacts the infant or toddler's functional performance, team members should be knowledgeable about the range of typical development based on the infant or toddler's chronological age and/or their developmental age.

- **Example of No Adverse Impact:** If an infant or toddler has restricted patterns of play but continues to socially interact, learn expected readiness skills and can transition to new activities with limited distress, functional performance is likely not adversely impacted to the extent that special education programs and services would be required.
- **Example of Adverse Impact:** A typical step in developing play skills for infants and toddlers is completing the same actions repeatedly or lining up items during play (i.e., restricted patters of play). However, if such behaviors significantly interfere with social interactions and engagement, or when interruption of these behaviors results in significant distress, the behavior is clearly impacting the infant or toddler's functional performance in the social and behavioral domains.

Need for Special Education Programs/Related Services

Identification of a disability alone does not guarantee eligibility for special education. The Michigan Mandatory Special Education Act mandates the provision of special education for "students with a disability" birth to age 26. The MARSE Rule 340.1702 defines "student with a disability" as a person who is determined to have 1 or more of the impairments covered by the MARSE that necessitates special education, related services, or both.

Evaluation Process

Data Collection

When evaluating infants and toddlers, the following must be considered:

Settings and Situations

For infants and toddlers, settings and situations are important components of the evaluation process. Information must be collected from a variety of people, across multiple environments, who are familiar with the child in order to determine the presence of diagnostic indicators, and any associated adverse impact.

It is essential for the evaluation team members to remember that "there is no single behavior that is always typical of autism and no behavior that would automatically exclude an individual infant or toddler from a diagnosis of autism"

(National Research Council, 2001). To minimize confirmation bias, team members are encouraged to look for evidence indicative of ASD and evidence contra-indicative of ASD throughout the evaluation process.

Existing Evaluation Information

For infants and toddlers with a clinical diagnosis of ASD, especially those who are also receiving private or public insurance benefit services, evaluation teams can expect to receive reports that include, at minimum, a developmental history and standardized test scores. If this information is relevant and current, it does not need to be repeated. However, IFSP teams are also required to determine whether the infant or toddler meets the MARSE eligibility criteria for ASD as well as determine the impact and necessity for special education services; it is likely that observations, interviews, and/or direct assessments may still be needed. A detailed, developmental and family history will also need to be conducted if one does not exist.

Face to Face Interviews

Education-based evaluations include an interview with the infant or toddler's parent/guardian. During the interview, the multidisciplinary evaluation team is advised to listen carefully for the behaviors that prompted the referral. This information is helpful in sorting-out information that may be related to ASD from other disability areas. The information that parents and guardians provide, whether or not the infant or toddler is determined eligible for special education under ASD, is important and should be highlighted both throughout the evaluation process and in the evaluation report.

If the infant or toddler spends time in a daycare setting or playgroup, the evaluation should include interviews with the daycare provider, caregiver, playgroup facilitator, and any current service provider(s). Because one of the goals of the education-based evaluation is to understand how the suspected ASD affects an infant or toddler in his or her natural environment during the day, including the impact on functional performance and the need for specially designed instruction, it is important to obtain information from those who interact with the infant or toddler (Klin, et al., 2000).

Direct Observations

Direct observations in a variety of natural contexts (e.g., home, daycare, playgroup) and across several days provide valuable information. Comprehensive observations can provide a more accurate picture of how the infant or toddler communicates, interacts, and responds to varying stimuli and demands as compared to peers, and consistent behavioral patterns across observations increase the validity of the presence or absence of relevant behaviors. It is strongly recommended that all members of the evaluation team conduct multiple observations across contexts.

An important consideration in conducting observations is creating opportunities to engage in activities with the infant or toddler. Interacting or observing interactions with the infant or toddler through play allows the evaluators to see how the infant or toddler responds to a variety of variables. This type of integrated observation will provide the observer greater opportunities to understand and consider underlying motivations and immediate contextual variables that may be impacting the presence of behaviors, which is crucial for making differential eligibility decisions. For example: Parent reports that an infant or toddler repeats words over and over. One might attribute this behavior to repetitive language or echolalia. However, when observed in the home, this behavior could appear more related to the infant or toddler wanting something (e.g., a cookie), and the parent not attending or responding to the request, resulting in the infant or toddler continually repeating the request. Having third party observers confirm such behaviors can assist in eligibility decisions and allow the multidisciplinary evaluation team to better explain these behaviors and perhaps offer intervention ideas to the family.

In addition, quantitative data should be collected within the qualitative observation process. This will highlight the intensity of behaviors and provide further support for the impact and need for special education. When observing the infant or toddler's social interactions, data can be collected on the frequency, intensity, and/or duration of spontaneous initiations with others as compared to other infants and toddlers, or on the number of verbal, visual, or physical prompts needed for the infant or toddler to complete daily routines that same-aged peers accomplish independently.

Standardized Tool Considerations

For educational evaluations, no single assessment method is sufficient for determining eligibility criteria under the MARSE ASD rule. The multidisciplinary evaluation team must utilize information gathered from multiple sources and methods and apply each to the components of the MARSE criteria. Commercially available standardized assessment tools (e.g., norm-referenced tests, checklists, and rating scales) may provide relevant information in making clinical diagnoses of ASD and may actually be required for some diagnoses (e.g., ADOS for ASD insurance benefit eligibility), but these measures are not based on the MARSE criteria and thus provide insufficient data for making MARSE ASD eligibility decisions.

Multidisciplinary evaluation teams should not use a predetermined battery of standardized assessment tools, but instead use select tools based on specific helpful features (e.g., answers a specific question that other assessment methods do not, corroborates observation). An ASD specific standardized tool may be a helpful component of the data collection process; however, it is not required by MARSE in evaluating for ASD nor should it be used as a stand-alone method of evaluation.

In determining if a standardized assessment tool should be utilized, evaluation teams should consider the following questions:

- Is the tool adequate technically to assist in making the MARSE ASD eligibility decisions?
- What is the purpose or intended outcome of using the tool?
- What questions might be answered by using the tool, and will the tool provide that information? Is the information necessary and useful in making the eligibility decision?
- What are the language requirements of the test? Does it match the ability level and communication modality of the infant or toddler?
- Given the infant or toddler's behavioral challenges, will the tool likely produce reliable and valid results?
- How current is the tool (i.e., when was it published and standardized)?

The way in which data are used for an infant or toddler with limited English proficiency must be carefully considered to ensure an accurate measure of an infant or toddler's speech and language skills in all languages available to an infant or toddler, not only English language skills. Any adaptations of standardized test administrations should be described in the team report. Reporting norm-referenced standard scores for standardized assessments in which the normative sample is different from the infant/toddler being assessed, even in cases where the speech and language pathologist interprets or translates items from English into an infant or toddler's native language, is not a valid assessment practice. Instead, use descriptive practices and accuracy ratings to describe an infant or toddler's communicative functioning in all languages of exposure.

Data Analysis

It is important to not only collect data but also to interpret it from the perspective of identifying indicators and contra-indicators of the MARSE characteristics of autism. Behaviors must be present in a variety of environments and with a variety of people over time.

An education-based evaluation process at the stage of data analysis may include a summary meeting of the multidisciplinary evaluation team. Once all the observations and interviews have been conducted and all evaluation data collected, the evaluation team may elect to come together to review the information. The purpose of this optional meeting is to collectively reach a team decision regarding a recommendation of eligibility, as well as to begin formulating an impact and need statement that can serve as the basis for the development of the MMSE eligible infant or toddler's IFSP. Although there may be multiple ways to conduct such a meeting, the Results Review Meeting process is an effective way to analyze the data.

Once all the information collected has been reviewed, the team uses the preponderance of the evidence available to answer the eligibility criteria questions:

- Is there a qualitative impairment in **social interaction**?
- Is there a qualitative impairment in **communication**?
- Is there the presence of **repetitive, restricted, and stereotyped behaviors**?

If the answer to **any one of these questions** is "no," the infant or toddler does not meet the MARSE eligibility criteria for ASD and the possibility of eligibility in another disability category should be considered.

If the answer to **each question** is "yes," the MARSE ASD eligibility criteria are **met** and the team can go back and identify specific criteria that best represent each category. As a reminder, for the criteria to be met, at least two areas must be present in the reciprocal social interaction domain, at least one area in the communication domain, and at least one area in the restricted and repetitive behaviors domain.

To find an infant or toddler eligible under the category of ASD, the following factors must be true:

1. Infants and toddlers must meet the MARSE **eligibility criteria** for ASD;
2. The ASD must **adversely affect** the infant or toddler's functional performance in one or more of the following areas:
    a. Academics/Pre-Academic (e.g. functional performance in such age-appropriate activities as communication, engagement in routines, emerging readiness skills, social engagement)
    b. Behavior
    c. Social Domains, and
3. The impact must **necessitate special education** programs and/or related services.

Eligibility Recommendations

In addition to considering the complexities and range of developmental changes in infants and toddlers and having a solid understanding of the range of typical development, relevant experiences, and opportunities in early childhood that may impact development, consideration of the following areas is crucial when recommending eligibility for special education under ASD in infants and toddlers.

Careful Consideration of Development

Given that the rate of development can vary, the evaluation team must carefully consider differences in development of communication, social, and behavioral skills.

For example, if a two-year-old toddler displays a significant communication delay, as well as some difficulty with reciprocal social interactions, the multidisciplinary evaluation team should consider whether the social difficulties are a result of the significant communication delays rather than a presentation of a qualitative social impairment related to ASD.

Additionally, this same toddler may present with motor mannerisms such as hand-flapping when excited, which for some toddlers is part of the range of typical development. As such, it would be a stretch to consider it representative of repetitive behavior that would meet ASD criteria.

In this scenario, the multidisciplinary evaluation team may determine the toddler meets speech and language impairment (SLI) criteria under R 340.1710 by considering the social deficits are a result of the communication delay and the hand-flapping within the range of typical development. In this way, SLI is more representative of the infant or toddler's current developmental profile.

Additional Risk Factors

Consideration should be given to any additional risk factors that were indicated during the evaluation process that may be impacting the infant or toddler's performance, rather than an ASD, such as:

- Are there significant **medical issues** present that may be impacting the infant or toddler's communication, social, and behavioral development? For example, was there a traumatic brain injury after birth, exposure to toxins (e.g., lead, alcohol), or hearing loss?
- Does the infant or toddler's current **environment support** the development of language and social interaction? For example, was the infant or toddler raised in an environment with very limited exposure to language or socialization from caregivers? Did the infant or toddler experience significant trauma or exposure to ongoing trauma, stress or environmental toxins? Were play opportunities limited due to lack of toys or lack of exposure to other infants?
- Knowing the **cultural expectations** of an infant or toddler's home and family are an important consideration in assessing the social and behavioral indicators. For example, the absence of eye to eye contact or limited social interactions may reflect cultural expectations and, therefore, should not be viewed as a disability indicator.

Gender and Racial Differences

Gender Differences

Research of toddlers with ASD has shown that males are identified with ASD at a greater rate than females. Consideration of gender-specific characteristics that may mask females with ASD is important in the eligibility process:

- Females may exhibit: better language ability, stronger in memory, cognitive flexibility, verbal fluency, social communication
- Males may exhibit: aggression and hyperactivity leading to a clinical evaluation more so than females (Nichols, S., et.al.(2009); Reinhardt, V. P., et.al.(2015)).

Racial Differences

- Racial disparity exists in early detection and treatment of ASD. White children are identified more frequently and at an earlier age than black and Hispanic children. In addition, black and Hispanic children receive developmental evaluations later than white children. (CDC, 2016, March 31; Mandell, D. S. et.al.(2009)).

Clinical/Medical Evaluation Information

For infants and toddlers with a clinical diagnosis of ASD, standardized assessment and developmental information is often available from outside agencies or clinicians. This information is often relevant for the education-based evaluation; However, **a clinical diagnosis of ASD does not meet the MARSE ASD eligibility criteria** and this information alone is insufficient for making an ASD eligibility recommendation.

When outside agency or clinical documentation is provided, it must be considered in the education-based evaluation process; however, the final determination of educational eligibility will most often require additional assessments or observations. Direct observations, parent interviews, and/or additional assessments may still need to be conducted to make a recommendation for eligibility.

Given the differences in tools and processes, it is not uncommon for families, educators, and professionals to be confused by the discrepancy between a clinical diagnosis of ASD and educational eligibility. It is important for multidisciplinary evaluation team members and clinical evaluators to work collaboratively in assisting family members and others involved in the evaluation process to understand the differences and the reasons the differences exist.

For additional information regarding the differences between a medical and educational evaluation, see the Michigan Autism Council 'Education-based Evaluations for Autism Spectrum Disorder' resource.

Avoidance of an ASD Eligibility Determination

The multidisciplinary evaluation team should not apply a "wait and see" approach to determine if an infant or toddler's developmental delay or behavioral challenges meet ASD criteria. When applied, the following rationale are detrimental to the eligibility determination process:

- The **family is not ready** to hear the word "autism" or is uncomfortable with Autism Spectrum Disorder as the eligibility category.
- The **service provider is uncomfortable** telling a family that an infant or toddler meets the ASD criteria.
- The **evaluation team has uncertainty** assessing the impact of additional risk factors on development versus presentation of ASD characteristics.
- The evaluation team is hesitant to check the "**Lifelong Disability**" box on the eligibility determination form.

If, after careful and comprehensive assessment, the infant or toddler fully meets the criteria for eligibility under ASD, the multidisciplinary evaluation team must provide the recommendation of ASD eligibility to the IFSP team. The practice of determining an infant or toddler meets eligibility in the categories of R 340.1710 ("Speech and language impairment" defined; determination) or R 340.1711 ("Early childhood developmental delay" defined; determination) to "wait and see" if the infant or toddler meets ASD criteria must be discontinued.

Termination of Eligibility

A toddler's eligibility for special education under the MARSE does not terminate because the child ages out of Part C. At age three, special education services will be provided through an IEP vs IFSP process.

Eligibility is terminated when:

- The parent/guardian revokes consent for special education
- A reevaluation results in a redetermination either through the IFSP or IEP team (depending on the age of the child) that the infant or toddler no longer meets ASD criteria or that no longer has adverse impact requiring special education.

Appendices/Resources/Citations

- Appendix A: Autism Spectrum Disorder Eligibility Guidance Chart for Infants and Toddlers
- Appendix B: Comparing Education Based and Clinical Standards for ASD
- Appendix C: Practice Tips

- A Statewide Autism Resources and Training (START), Grand Valley State University
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Appendix A: Autism Spectrum Disorder Eligibility Guidance Chart for Infants and Toddlers

Chart is intended as a **supplement** to the *Determination of Eligibility for MMSE for Infants and Toddlers, Birth to Age Three ASD* Guidance document to assist with the analysis of data as it pertains to the evaluation of infants and toddlers. Fundamental to the evaluation of infants and toddlers birth to age 3 is: 1) a comprehensive understanding of age-appropriate development, 2) keen observational skills, 3) careful analysis of the data as compared to typically developing infants and toddlers, 4) consideration of alternative explanations for atypical behavior, and 5) an evaluation process that is analytical in nature rather than mechanical. Typical and marked atypical examples provided in this document are some of the most common ones and are not intended to be an all-inclusive list.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
R340.1715(1) "ASD is considered a lifelong developmental disability…typically manifested before 36 months of age."	• Evaluators need to be mindful that the "lifelong" in the ASD definition as it is the condition that is lifelong, not necessarily the eligibility or adverse impact requiring special education. • Evaluators are encouraged to focus on the infant or toddler's current functioning and the preponderance of evidence demonstrating that the infant or toddler currently meets the eligibility requirements. • IDEA regulation 300.304 clarifies that progress in the general curriculum for a preschool child is participation in age appropriate activities.	Intentionally Left Blank	Intentionally Left Blank	Intentionally Left Blank

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
	Therefore, the functional equivalent of educational performance (i.e., academic, behavior, social) for an infant or toddler would be functional performance in such age-appropriate activities as communication, engagement in routines, emerging readiness skills, social engagement). • It is critical for evaluators to understand and recognize typical child development and engagement in familiar and non-familiar routines in to differentiate typical development from atypical. As such, evaluators are strongly encouraged to observe typical infants and toddlers and review developmental inventories regularly.			
"ASD is characterized by…" (See 3 domains below)	• ASD eligibility can only be recommended if criteria are met in all 3 domains.	Intentionally Left Blank	Intentionally Left Blank	• To minimize confirmation bias, team members should consider and document indicators and contra-indicators for the ASD rule-required characteristics, including alternative

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
				explanations for observed deficits, such as other developmental disorders, environmental variables, and/or cultural factors.
Domain 1: (2)(a) Qualitative impairments in reciprocal social interactions, including at least 2 of the following 4 areas:	A "qualitative impairment" is: • identified as atypical or considerably different from other infants and toddlers the same age • evident across multiple environments and social partners	• It is critical for evaluators to understand and recognize the use of non-verbal behaviors in typically developing infants and toddlers. • Nonverbal behaviors change considerably during birth-3 development, so evaluators are encouraged to frequently observe typical infants and toddlers at these ages and/or utilize developmental inventories for comparison.	• Areas (i)-(iv) should be viewed as resulting from a qualitative impairment in reciprocal social interaction as it relates to ASD and not merely delays or differences in these areas. Because typical infants and toddlers and infants and toddlers with other disabilities can present with deficits in reciprocal social interaction, alternative reasons for such deficits should be considered.	• It is critical for examiners to consider alternative explanations for deficits in reciprocal social interaction including the presence of other developmental disorders, environmental variables (e.g. neglect, exposure to trauma), and personal / cultural factors.
Area (i): Marked impairment in the use of	• Marked impairment for this area means: ◦ substantial and sustained difficulty in the quality and	**9-12 Months** • Smiles in response to adult smile	**9-12 Months** • No smile in response to adult smile	• Consideration should be given to the infant and toddler's cultural environment and the

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.	functionality of using nonverbal behaviors to regulate communication with a social partner ◦ difficulties are clearly evident and observed across multiple environments and people over time • Criterion is not intended to merely define the presence or absence of nonverbal behavior, but also the use of nonverbal behavior to regulate social communication, particularly where words fail.	• Engages in eye gaze frequently • Seeks out faces frequently • Gains attention by making physical contact (e.g., grabbing) • Requests objects by pointing • Reaches to be picked up • Initiates social game (e.g., puts blanket on head for peek-a-boo) **12-18 Months** • Responds to name when called • Uses eye contact / gaze to initiate, sustain, or terminate social interaction • Gives objects to adult to request help • Spontaneous use of or understanding of common gestures (e.g., following a point, pointing to show something, head nod yes, wave bye, clap to show excitement)	• Infrequent or fleeting eye gaze/ aversion • Infrequently looks at others' faces • Shows little/no pleasure in interaction/social play with adults • Rarely seeks out social interaction • May show pleasure in play actions (e.g., peek a boo) but not in the adult's smiles or laughs **12-18 Months** • Rarely responds to name • Has limited, fleeting or no eye contact or eye gaze to initiate, sustain, or terminate social interaction • Lacks spontaneous use of or understanding of common gestures (e.g., following a point, pointing to show something, head nod yes, wave bye, clap to show excitement)	expectations regarding the use of nonverbal behaviors.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		• Points to objects upon request (e.g., show me your tummy) **18-24 Months** • Uses facial expressions and sounds to gain attention (e.g., makes funny faces, silly sounds) • Developing representational gestures (e.g., shrugging shoulders, putting hands up to indicate 'what's that' or 'where did it go') • Uses common gestures (e.g., blows kisses, gives 'high five') **24-36 Months** • Imitates familiar actions (e.g., claps hands) • Points to named people and objects	• Does not follow a point or look to something pointed to across the room from a familiar adult **18-24 Months** • Does not use facial expressions or sounds / noises to gain attention from adult • Lacks use of representational gestures (e.g., shrugging shoulders, putting hands up to indicate 'what's that' or 'where did it go') • Lacks use of common gestures (e.g., blows kisses, gives 'high five') **24-36 Months** • Does not imitate familiar actions (e.g., claps hands) • Does not reach up to be picked up • Does not point to named people and objects	

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
Area (ii): Failure to develop peer relationships appropriate to developmental level	• The phrasing of this characteristic is extremely important to consider. It recognizes that there are incremental developmental stages in peer-to–peer social reciprocity. Therefore, evaluators should be keenly aware of these stages of development	**9-18 Months** • Shows interest in babies / young children (e.g., staring, smiling) **18-24 Months** • Engages in parallel play (plays adjacent to partner and appears interested in the others' play but does not enter it) • Demonstrates shared interest, rough and tumble play • Demonstrates enthusiasm for interaction with peers **24-36 Months** • Enters play or social circles fluidly • Demonstrates some flexibility in rules / expectations of play • Initiates and sustains interactions with peers • Demonstrates understanding of social cues or the communication intent of others	**9-18 Months** • Appears uninterested in babies /young children **18-24 Months** • Preference for solitary play (i.e. does not appear interested in the play of those around) • Does not appear to enjoy rough and tumble play • Low interest in same-age peers **24-36 Months** • Disrupts ongoing activities when entering play or social circles • May insist on controlling the play when engaging with others • Lacks initiation or sustained interactions with others • Misinterprets social cues or the communication intent of others	• Examine alternative explanations for a perceived "failure to develop peer relationships appropriate to developmental level", such as, a lack of opportunity to engage in peer interaction, cultural factors, and possible cognitive impairment. • Differentiate immature play from lack of social interactions or opportunities. • Consider infant or toddler's attempts to imitate peers and show interest and/or attempts to interact. This may demonstrate the desire to engage with others.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		• Demonstrates spontaneous engagement in conversation or activity with peers	• Tolerant of peers but no spontaneous engagement in conversation or activity with peers	
Area (iii): Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., a lack of showing, bringing, or pointing out objects of interest)	• "Marked impairment" in this area means: ◦ substantial lack of spontaneous (i.e., without prompting) sharing and showing, often referred to as joint attention* • Observational data on spontaneous seeking to share may include, but is not limited to: ◦ How the infant or toddler draws the attention of others to his or her completed tasks ◦ How the infant or toddler attempts to initiate social interaction ◦ How the infant or toddler socially directs their smile or smiles in response to another ◦ How the infant or toddler points out objects of interest to share enjoyment ◦ When observing, look for joint attention and if	**9-18 Months** • Alerts adult to an object by means of eye gaze or point • Looks in the direction of an object when adult looks that way or points in that direction • Looks to adult when accomplishes something (e.g., takes a step) **18-24 Months** • Alerts adult to an object or situation by means of back and forth (object to adult) eye gaze or pointing • Gives or shows object / toy as if to share excitement (not just to make it work) **24-36 Months** • Looks at an object while adult is looking	**9-18 Months** • Looks at objects without attempts to alert adult to look at the same • Limited looks in the direction of others' points or gaze • Does not seek out others' during accomplishments or excitement of objects **18-24 Months** • Few attempts to alert adult to an object or situation by means of back and forth (object to adult) eye gaze or pointing • Brings objects to adult to get it to work but not for a shared experience **24-36 Months** • Fails to look at an object while adult is	• Examine alternative explanations for impairment in spontaneous showing and sharing, e.g., access to materials, engagement with important adults in the environment, previous trauma, or general neglect.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
	necessary create opportunities to observe interactions between the infant or toddler and others in the natural environment. Look for this sequence: an infant or toddler sees an item/event, then looks to the other person to see if partner is looking at the same item/event, and then looks back at the item/event. They are sharing the experience. *Joint attention is defined as the shared focus or experience of two or more individuals on an object or activity (Oates & Grayson (2004). This typically begins to develop around two months of age with dyadic (i.e., two persons) exchanges using looks, noises, and mouth movements. Lack of joint attention is often the result of deficits in understanding others' perspectives.	at the object and shows awareness the adult is also looking at the object (triadic attention) • Shows / shares an accomplishment with enthusiasm as if to seek the same excitement (e.g., completed puzzle) • Responds to others • Demonstrates sharing of enjoyment, interests, or achievements (i.e., not just focusing on one's own interest)	looking at the object with awareness the adult is also looking at the object (triadic attention) • Limited attempts to show or share achievements (e.g., completion of a puzzle) or interest with familiar adults • Inconsistent or lack of response to others' sharing of enjoyment, interests, or achievements (e.g., shifting to one's own interest rather than responding to the interests of others)	
Area (iv): Marked impairment in the areas of	• "Reciprocity" is defined as the mutual give and take of social interactions and refers to how the behavior of one person influences and is influenced	**9-18 Months** • Seeks familiar adult to be soothed when upset	**9-18 Months** • Exhibits highly unusual and persistent attachment to objects	• Social interactions can be influenced by the infant or toddler's history of reinforcement. An

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
social or emotional reciprocity	by the behavior of another person and vice versa. • Social and Emotional Reciprocity is defined as back and forth flow of social and emotional expression. In infants and toddlers, emotional reciprocity is seen with mutual affective behaviors such as smiles, laughter, and grimaces and social behavior such as imitation and hugs. Social reciprocity is seen through attempts to imitate others' behaviors and clapping or cheering for themselves and others for accomplishments. • Marked impairment in this area implies significant difficulty recognizing and responding to the needs, intentions, perspectives, and feelings of others across multiple environments and people over time.	• Frequent use of social smiling and responding to adult smiles • Easy to soothe through social calming practices when upset (e.g., cuddling, verbal reassurance) • Attempts to imitate the actions of others (e.g., waving, pointing) **18-24 Months** • Imitates the play of others • Enjoys social games and play routines (e.g., peek a boo) • Looks to familiar adult for how to respond to novel / unusual social situations • Seeks out support when upset **24-36 Months** • Highly interested in ideas of others, often seen during play • Preference for interaction with others	(rather than people) to help soothe them. • Limited to no use of social smiling; rarely offers spontaneous social smiles • Difficult to soothe with common calming practices (e.g., cuddling) • Little attempt to imitate the actions of others **18-24 Months** • Lacks imitative play • Does not enjoy social games or play routines (e.g., patty cake, peek-a-boo and finger play) • Does not look to a familiar adult for cues to respond to a novel or unusual social situation • Does not seek out cuddling when upset **24-36 Months** • Lacks interest in ideas of others, often seen during play	infant or toddler raised in an environment not rich in reinforcement of social interactions, such as eye contact or pointing out items of interest, may not be as likely to display those behaviors. • An infant or toddler exposed to trauma may show social interaction deficits that mirror characteristics of ASD. • It is important to differentiate between an infant or toddler who is shy with strangers and one who does not display the above behaviors with familiar adults. Due to the nature of evaluations of infants and toddlers under three, every attempt should be made to collect data on the presence or absence of these behaviors in natural routine-based interactions with

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		• Demonstrates an understanding of how their behavior impacts others • Understands concepts of social conventions (e.g., turn-taking, politeness, social space) • Demonstrates appropriate response to someone else's pain or distress (e.g., shows concern when others are upset)	• Demonstrates aloofness and indifference toward others • Fails to understand how own behavior impacts how others think or feel • Difficulty with social conventions (e.g., turn-taking, politeness, social space) • Lacks appropriate response to someone else's pain or distress (e.g., laughs when others are upset)	familiar adults or peers. • Chronological age, developmental level, and the infant or toddler's opportunity to learn or experience these skills should always be considered when determining if a marked impairment exists.
Domain 2: (2)(b) Qualitative impairments in communication including at least 1 of the following 4 areas:	• A qualitative impairment is defined as: ◦ Atypical or considerably different from other infants and toddlers the same age ◦ Evident across multiple people and environments.	• It is critical for evaluators to understand and recognize the development of communication skills in typically developing infants and toddlers. Communication skills change considerably during birth-3 development, so evaluators are encouraged to frequently observe typical infants and	• The areas below should be viewed as resulting from a qualitative impairment communication as it relates to ASD and not merely delays or differences in these areas. Because typical infants and toddlers with other disabilities can present with deficits in communication, there may be alternative reasons for such	• Examiners should consider alternative explanations for impairment in communication, including other developmental disorders, environmental variables, and cultural factors.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		toddlers at these ages and/or utilize developmental inventories for comparison.	deficits that should be considered.	
Area (i): Delay in or total lack of the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime.	• For infants and toddlers, communication is often nonverbal in nature and the measure of an infant or toddler's communication is an evaluation of the language skills compared to his/her developmental level as well as evaluating the infant or toddler's attempts to communicate through nonverbal or alternative means. Don't rely solely on lack of language.	**9-18 Months** • Babbles or sound plays (baba, gaga) • Speaks first word by 16 months even if imitated **18-24 Months** • Speaks f spontaneous word by 18 months • Uses meaningful two-word phrases by 24 months **24-36 Months** • Uses two- or three-word or longer phrases and sentences • Asks for or directs attention to objects by naming them • Uses nouns and action words • Has short conversations about known topics • Uses language for a wide variety of	**9-18 Months** • Limited babbling or sound play • Lacks development of words or development of a word or two and then losing its use **18-24 Months** • Does not seem to recognize that words have a communicative intent • Does not use words or meaningful two-word phrases **24-36 Months** • Uses adults as a tool to communicate (e.g., pulling an adult to a particular area to get a snack or toy) without looking at them for communicative purposes	• Evaluators are encouraged to note the infant or toddler's ability to use any manner of communication in a functional/purposeful way to differentiate between mere word /sound production versus communicative intent. • Some infants and toddlers fail to develop language yet compensate by using alternative communication modes such as gestures, facial expressions, and other nonverbal behaviors.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		purposes (e.g., to get something, to ask questions, to seek attention, to comment about experiences)	• Stands or screams near the refrigerator in the absence of an adult • Uses words for self-stimulation or predictability versus interacting with others (e.g., echolalia, jargon, gibberish, mumbling) • Uses challenging behavior (e.g., hitting, biting, pushing, screaming) in lieu of alternate communication • Loss of previously acquired speech	
Area (ii): Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others.	• Pragmatic language refers to the ability to use new language skills in reciprocal social interaction with peers. • Deficits in pragmatics for infants or toddlers with ASD result from deficits in understanding the perspectives of others and lack of social reciprocity. • Around the age of four, typically developing children: ◦ Understand that they need to talk differently to their preschool teacher than to a	**9-18 Months** • Imitates facial expressions • Exchanges gestures with an adult • Vocalizes to gain attention and to call others • Talks or babbles with varied pitch, tone and cadence • Initiates turn-taking games/routines	**9-18 Months** • Does not respond with eye gaze or vocalization when called • Lacks showing or giving objects to share interest, get assistance • Does not point to show or request • Lacks vocalization, eye gaze, or gestures	• Pragmatic language becomes more complex as children get older and may be difficult to assess in infants and toddlers, particularly those who are not yet using words. Because of this, attention should be paid to the way in which a child uses nonverbal communication to initiate interaction and

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
	peer than to a younger child ◦ Understand the importance of getting another person's attention before talking to them ◦ Use words to request things and communicate their approval and disapproval ◦ Direct their language to social interactions with adults and peers • Verbalize out loud their "private speech" about their thoughts, feelings, and hopes as they play and interact with others	• Brings objects to show an adult • Requests objects by pointing and vocalizing or using word approximation • Solicits another's attention vocally, physically, and/or possibly with gestures • Requests action/assistance through gesture (e.g., gives back wind-up toy for activation) • Says "bye" and possibly a few other conventional ritual words such as "hi," "thank you," and "please" • Protests by saying "no" shaking head, moving away, frowning, or pushing objects away • Comments on objects/actions by directing listeners' attention to it with a point and/or vocalization or word approximation	to get another person's attention • Displays challenging behavior to protest instead of using words • Does not initiate turn-taking games/routines **18-24 Months** • Does not integrate the use of words, eye gaze, and gestures to initiate and regulate interaction with others (may use only one of these forms of communication) • Does not engage in verbal turn-taking **24-36 Months** • Does not respond to the emotions of others • Difficulty with turn-taking in play or conversation • Uses and/or responds to questions and comments in ways that are inappropriate or not relevant (i.e. strange or out of place)	respond to others in social situations.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		• Answers simple "wh" questions with a vocal response (may be unintelligible) • Acknowledges speech of another by giving eye contact, vocally responding or repeating a word said • Uses gesture plus vocalization or word approximation to tease, warn, or scold **18-24 Months** • Uses gestures with words to get needs met • Says "what's that?" to elicit attention • Begins using single words and some two-word phrases to command (move), indicate possession (mine), express problems ("Ouch") • Vocalizes and uses verbal turn-taking **24-36 Months** • Begins using and displaying basic	• Comments are limited to particular area of interest	

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		emotions: happy, sad, mad • Enjoys being next to same-age children		
Area (iii): Stereotyped and repetitive use of language or idiosyncratic language.	• Infants and toddlers with ASD may exhibit language that is: ◦ Stereotypical: use of nonsense words or phrases or verbal fascinations ◦ repetitive, or ◦ idiosyncratic language: contextually irrelevant, not understandable to the listener due to a private meaning • The key to evaluating for this characteristic is not just identifying the presence of stereotypical, repetitive, or idiosyncratic language, but also identifying the absence of an associated functional/ purposeful/relationship-based communicative use of such language.	• Typical infants and toddlers demonstrate verbal fascinations through sound and word play; however, they will enjoy this play with familiar adults. Infants and toddlers with ASD tend not to engage with adults in such play. • Typical infants and toddlers engage in the use of repetitive language from a history of reinforcement (e.g., asking for a cookie and not getting it so repeating it over and over). It is critical to consider context during observations to ensure that repetitive words are not due to this type of typical development.	• Evidence of stereotyped, repetitive, or idiosyncratic language may include, but is not limited to, the following: ◦ Repeating words or phrases ◦ Repeating what others say (echolalia) immediately after the person said it or at some time in the future ◦ Repeating television or movie lines, song lyrics, or other media that are out of context and add no meaning to the conversation • Use of words with a private meaning that only makes sense to those who are familiar with the situation	• Examine alternative explanations for repetitive use of words / language such as other developmental disorders (e.g., cognitive delay) or a history of reinforcement with important adults.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
			where the phrase originated (e.g., states "That's right on the money!" every time the toddler enters the room)	
Area (iv): Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.	• Spontaneous make-believe play is a precursor to the use of symbols and corresponds with language development. Social imitative play is also thought to be an early sign of social reciprocity. • Play schemes and make believe are developmental and may be limited in infants and toddlers. When assessing play skills, evaluators are encouraged to pay attention to the infant or toddler's ability to begin varying and/or expanding on schemes. • Observation during play with typical peers is highly recommended whenever possible when conducting infant and toddler evaluations for ASD.	**9-18 Months** • Object exploration—Explores an object, but does not assimilate how to use it in play (e.g., makes a stirring motion with a spoon and then drops it) • Directs play towards another person (e.g., picks up the pretend cell phone, makes ringing sound, hands to person) **18-24 Months** • Representational play—Uses "meaningless" objects in a creative way to play a role in pretend play (e.g., block becomes a cell phone or a train) • Parallel play—plays next to, but not with,	**9-18 Months** • Intense attention to few objects; may not manipulate to explore • Does not include others in play **18-24 Months** • Difficulty moving beyond repetitive play to symbolic play • Lines up toys like cars or trains, stuffed animals, or action figures • Lacks finger play (e.g., "Itsy Bitsy Spider") imitation without specific teaching and prompts **24-36 Months** • Lacks spontaneous pretend play with toys (e.g., use objects only as intended)	• Consider alternative explanations for lack of varied play such as lack of opportunities or cultural and/or environmental factors (e.g. lack of play objects). • Obtain contextual information during observations to assist in differentiating between ASD-related play deficits and alternative causes, (e.g., environmental issues, lack of opportunity to learn play skills). To rule out lack of opportunity to learn play skills, the evaluator may set up experience(s) to see how the infant or toddler responds to direct instruction in play.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		other infant or toddler; may not appear to interact with but is very aware of the presence of other infant or toddler **24-36 Months** • Play moves from objects to imaginary objects or beings (e.g., swing becomes a spaceship, cup has pretend tea in it) • Begins to animate toys (pretends to feed a doll that is hungry)	• Little elaboration on learned play schemes • Focuses on one part of toy rather than actually playing with it (e.g., wheels on a toy car or train, the string of a pull toy) • Focuses on movement of the toy rather than the purpose of the toy (e.g., stack blocks but not build anything • Limited play repertoires compared to peers (e.g., plays with one specific toy) • Directs peers to their assigned role in play, rather than play • Engages in construction play (e.g., puzzles, setting up elaborate train track layouts) at the exclusion of flexible representational play	
Domain 3: (2)(c) Restricted range of interests or repetitive behavior including	• Infants and toddlers with ASD engage in restricted, repetitive, and stereotyped behaviors that are extreme and often interfere with other more appropriate behaviors or daily life.	• For infants and toddlers, repetitive behaviors or restrictive scopes of interest are developmentally typical	• Behaviors and/or interests become dominant across environments and interfere with the infant or toddler's engagement	• Alternative explanations for impairment in spontaneous seeking to share or enjoy interests with other people include other

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
at least 1 of the following 4 areas:	• Because infants and toddlers with ASD are driven to engage in these behaviors, they are difficult to stop or control. Further, disrupting the behaviors often causes significant distress for the infant or toddler. • Evaluators should pay attention to the frequency, intensity, and duration of the behavior, focus of the behavior, and if the behavior interferes with functioning.			developmental disorders, environmental variables, and cultural factors
Area (i): Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.	• Infants and toddlers with ASD can display intense interests and preoccupations that are intrusive, reoccur frequently, and interfere with participation in daily activities. Limited access, interruption, or removal of the activity or interest often causes significant distress. • The degree to which behaviors are, or become persistent and encompassing, are key considerations in the evaluation process. In other words, the behavior(s) of concern would be present across settings and situations, not just with some people or in some situations.	• Talks about a variety of interested topics, and switches topics with prompting • Plays with a variety of toys and will tire of certain toys if played too much • Knows the plots of movies / cartoons but doesn't use them as the lens through which experiences or the world is viewed • May have temper tantrums when transitioning from preferred interests, but is able to be soothed	• Talks about a particular topic (e.g., Bubble Guppies) incessantly without regard to the conversational partner • "Playing" with the same toy over and over, in the same way each time, beyond the typical development of play • Uses a specific video game, television show, or movie as the lens through which experiences or the world are viewed • Excessively seeks access to, or talking	• Alternative explanations for impairment in spontaneous seeking to share or enjoy interests with other people include other developmental disorders, environmental variables, and cultural factors.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
		• Interests are typical of other infants and toddlers the same age • Interests do not significantly interfere with daily routines of the family	about, atypical interests such as historical events, specific appliances (e.g., vacuum cleaner or fan), or unusual types of animals (e.g., white Siberian tiger) • Intensity of interest significantly interferes with daily routines of the family (e.g., infant or toddler with interest in trains screams in car until mom drives over railroad tracks; family leaves infant or toddler's Lego structure in front of TV and the family views the TV around the structure) • Carries around unusual or uncommon objects for extended periods of time	
Area (ii): Apparently inflexible adherence to specific,	• Infants and toddlers with ASD seek predictability in their environments and thus may create and follow nonfunctional routines or rituals or have extreme	• Challenges with transitioning between activities are developmentally to be expected; however, typically developing	• Wears a specific clothing item for a specific day or activity • Has rigid adherence to specific sequences in routines or self-imposed rules (e.g.,	• Alternative explanations for impairment in spontaneous seeking to share or enjoy interests with other people include other

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
nonfunctional routines or rituals.	distress when their routines are altered. • Evaluators are encouraged to pay more attention to an infant or toddler's insistence on nonfunctional routines which, when disrupted, make everything go awry.	infants and toddlers can be soothed	must eat or put clothes on in certain order) • Excessive and time-consuming routines (e.g., bathroom, dressing) • Distress when daily routines and schedules are altered • Insistence that others follow rules, including rules made up by the infant or toddler	developmental disorders, environmental variables, and cultural factors.
Area (iii): Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements).	• Some infants and toddlers with ASD engage in repetitive motor mannerisms, often called self-stimulatory behaviors.	• Typically developing infants and toddlers do not generally engage in these behaviors. They may have occasional flapping or finger movements however, so this item should be taken into consideration with the other criteria.	• Preoccupation with fingers, spinning, and twirling objects or self • Paces in a particular manner or routine • Smells, chews, or rubs objects in a particular manner • Rocks or lunges • Persistent grinding of teeth • Repeated visual inspection of objects • Self-injurious behaviors including head-banging, hand biting, and excessive self-rubbing and scratching	• To avoid confirmation bias, it is important evaluation teams do not consider this area in isolation, because these behaviors exist in other disability areas, and can exist in typically developing infants and toddlers.

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
			• Moves body parts in an odd and/or repetitive manner	
Area (iv): Persistent preoccupation with parts of objects.	• Infants and toddlers with ASD can become preoccupied with parts, objects, or processes. The fixation may appear to be more focused on how an object, including toys, actually works instead of the function that it serves.	• Typical infants and toddlers explore items and may look at the parts of objects but are not overly focused or obsessed with the parts versus the whole and use of the object.	• A fascination with a specific part of the dishwasher or vacuum cleaner • Spins the wheels of a car • Watches several seconds of a movie or cartoon repeatedly, without watching the complete movie, outside of typical development and in the absence of shared enjoyment with a parent or caregiver • Completes complex puzzles with more interest in putting the pieces together than the puzzle picture as whole	• Alternative explanations for persistent preoccupation with parts of objects may include cognitive delay or other developmental challenges.
Other Evaluation Considerations: Unusual or Inconsistent Response to Sensory Stimuli	• According to MARSE, determination of ASD may include unusual or inconsistent responses to sensory stimuli, but to be eligible under ASD, the infant or toddler must also meet the other three domains of	• Typically developing infants and toddlers can have sensitivities to sensory information so this item must be taken into consideration given the other criteria.	• Infants and toddlers with ASD may seek or avoid certain sensory stimuli to a degree that it interferes with daily activities. Specific sensory areas can include sight,	• Given that unusual or inconsistent responses to sensory stimuli can occur in typically developing infants and toddlers, and in infants and toddlers with other disabilities,

Rule	General Guidance	Examples of Typical Development	Examples of Marked Atypical Development	Thinking Points for Differential Decision-making
	eligibility. Sensory challenges alone are not sufficient to identify the student as ASD because sensory issues can be found in several other eligibility areas. **Conversely, the absence of sensory challenges does not exclude a student from meeting ASD eligibility criteria**. As such, the evaluation team should analyze the infant or toddler's response to sensory stimuli as it impacts the three domains of ASD eligibility (i.e. reciprocal social interaction, communication, and restrictive and repetitive behaviors).	• Generally, typically developing infants and toddlers with such sensitivities can be soothed by familiar adults.	touch, hearing, smell, taste, and movement.	this criterion must be considered in context of the other criteria.

Appendix B: Comparing Education Based and Clinical Standards for ASD

The purpose of an education-based evaluation is to determine a student's eligibility for special education programs or services under the MARSE criteria, not to provide a clinical diagnosis. However, according to the Michigan ASD State Plan survey (2012), there is often confusion between a clinical diagnosis of ASD and ASD special education eligibility criteria. The confusion is further exacerbated when a child receives a clinical diagnosis of ASD but then does not meet the education-based eligibility criteria under ASD. As such, it is important to outline the differences in process and purpose of evaluations between the two to enhance understanding across school personnel, clinical staff, and families. Below is a brief comparison of the various components of evaluation across the school and clinical models:

Process/Purpose	Education-Based Eligibility	Clinical/Medical Diagnosis
Purpose/Function	• Determine special education eligibility or ineligibility • Determine educational impact • Determine need for specially designed instruction • Inform IEP and special education services	• Make Clinical/Medical/ Behavioral Health Diagnosis • Determine insurance or Medicaid Autism benefit eligibility • Access non-educational agency services • Dictate medical/clinical treatment
Criteria/Tools to Make Determination	• MARSE ASD criteria • Use of tools individually determined based on what questions need to be answered	• Diagnostic and Statistical Manual for Mental Disorders Fifth Edition (DSM-5) • Clinical diagnostic assessment tools (e.g. Autism Diagnostic Observation Schedule (ADOS)) • For additional information, see Medical Services Administration (MSA) Bulletin 13-09
Team Members	• Multidisciplinary team including a psychologist/ psychiatrist, authorized provider of speech and language services, and school social worker are required	• Practitioners can make independent diagnostic decisions
Observations	• Multiple observations in varied environments over time	• Generally, includes observations in an office or clinic setting

Appendix C: Practice Tips

Domain #1: (2)(a) Qualitative Impairments in Reciprocal Social Interactions

- Marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction.
- Failure to develop peer relationships appropriate to developmental level.
- Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g. a lack of showing, bringing, or pointing out objects of interest).
- Marked impairment in the areas of social or emotional reciprocity.

Domain #2: (2)(b) Qualitative Impairments in Communication

- Delay in or total lack of the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime.
- Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others.
- Stereotyped and repetitive use of language or idiosyncratic language.
- Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

Domain #3: (2)(c) Restricted, Repetitive, and Stereotyped Behaviors

- Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
- Apparently inflexible adherence to specific, nonfunctional routines or rituals.
- Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements.
- Persistent preoccupation with parts of objects.