Parish Advocacy for persons with disabilities

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Handbook

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APPROPRIATE USE OF LANGUAGE

Disability A disability may or may not be handicapping, use disability rather than handicap. Ex. There are approximately 43 million individuals with disabilities in this country. People with disabilities are not looking for sympathy or pity, they are not "afflicted" or "suffering" from their disability — they just want to be treated respectfully as individuals.

Person First It is important to identify the person first, rather than the disability, by saying a person with a disability or a person that is deaf rather than a disabled person or a deaf person.

Conditions Because persons are not conditions, do not label individuals as the disabled, epileptics, post-polios, etc… Say, instead, people who have disabilities, have epilepsy, have/had polio, etc.

Wheelchair When referring to someone who uses a wheelchair say he or she uses a wheelchair rather than wheelchair bound or confined to a wheelchair. People are not confined to their wheelchairs, they use them for mobility.

Blindness Refers to total loss of vision. Not to be used when referring to partial vision which may be correctly called vision loss.

Congenital Disability
Described as a disability. The term "BIRTH DEFECT" is not appropriate because defect is not a synonym for disability.

Deafness Refers to total loss of hearing. Not appropriate when referring to partial hearing loss. Use hearing loss. Do NOT use Deaf Mute or Deaf and Dumb.

Learning Disability
A disability affecting the understanding or use of a spoken and/or written language.

Mental Illness/Mental Disorder
Terms such as mentally deranged, deviant and crazy are not appropriate. Mental illness is a comprehensive term that describes any mild, moderate or severe emotional disorder. Terms such as neurotic, psychopathic and schizophrenic are libelous labels.

Developmental Disabilities
A condition causing a person to have significantly below-average, general intellectual functioning. Labels such as moron and mentally deficient/defective are not acceptable. When referring to a specific condition such as Down's Syndrome, DO NOT use the term mongoloid or mongoloidism.

Speech Impairment
Limited or difficult speech patterns.

Autism Spectrum disorders that can be mild, moderate or severe. Shares many characteristics with Pervasive Developmental Disorder.

POINTS TO REMEMBER
WHEN YOU MEET A PERSON WHO HAS A DISABILITY

- Remember that we all have disabilities; on some of us they are more apparent.

- Remember that a person who has a disability is a PERSON - like anyone else.

- Speak directly to a person with a disability. Don't consider a companion to be a conversational go-between.

- Converse directly with the person who has the disability just like you would with anyone else. Take the time to explore mutual interest in a friendly way.

- Offer assistance if asked or if the need seems obvious, in which case ask simply, "Do you need help? How should I help you?" Respect the person's right to indicate the kind of help needed.

- Talk about the disability if it comes up naturally, without prying.

- Do not be embarrassed over common expressions that call attention to a disability. An example would be asking a deaf person if he/she has heard some news. It is more likely that you will be more sensitive to the expression than the person to whom you are talking.

- Appreciate what the person CAN do. Remember that difficulties the person may be facing may stem more from society's attitudes and barriers than from the disability.

- Be considerate of the extra time it might take for a person with a disability to get things said or done.

- Do not shout at a blind person. They have lost their vision, not their hearing. Use descriptive language when directing someone who is blind. Indicate distances and obstacles which might be in the way.

- Don't provide words for someone who stutters or speaks with difficulty. Be patient and listen. If you do not understand, be honest and ask the speaker to repeat. When necessary, ask questions that require short answers or a shake of the head.

- Always face a person with a hearing loss. Be sure the person can see your lips; speak clearly without exaggerating lip movements. Use gestures to aid communication. When full understanding is doubtful, write notes.

- Don't move a wheelchair or crutches out of reach of the person who uses them.

- Never start to push a wheelchair without first asking the occupant if you may do so. When pushing a wheelchair up or down steps, ramps, curbs or other obstructions, ask the person if he/she wants to proceed.

- When dining with a person who has trouble cutting, offer to help if needed. Explain to a person who has a vision loss where dishes, etc., are located on the table.

- When you attempt to help a person with a disability, remember to participate with him/her. Don't do things to or for him/her.

COGNITIVE DISABILITES
DEFINITION OF DEVELOPMENTAL DISABILITIES

The AAMR Definition of Developmental Disabilities

Developmental retardation is a disability characterized by significant limitations both in intellectual function and in adaptive behavior as expressed in conceptual, social and practical adaptive skills. This disability originates before age 18.

Five Assumptions Essential to the Application of the Definition

1. Limitations in present functioning must be considered within the context of the community's environment typical of the individual's age, peers and culture.

2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor and behavioral factors.

3. Within an individual, limitations often coexist with strengths.

4. An important purpose of describing limitations is to develop a profile of needed support.

5. With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation generally will improve.

arcfacts
Association for Retarded Citizens
INTRODUCTION TO DEVLOPMENTAL DISABILITIES

What is Developmental Disability?

People with developmental disability mature at a below average rate and experience unusual difficulty in learning, social adjustment and economic productivity. The most generally accepted technical definition describes developmental disability as "significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period."

In terms of IQ, individuals with developmental disability score below 70. This means that the measured intelligence of 97 percent of the general population is greater than that of persons with mental retardation. All areas of abilities are affected, and the condition exists from birth and/or early childhood. Developmental disability is not a disease, nor should it be confused with mental illness. Children with developmental disability grow into adults with developmental disability; they do not remain "eternal children." The big difference is that they learn more slowly and with much greater difficulty.

How Prevalent is the Condition?

Persons with developmental disability constitute one of the largest disability groups in America. They include more than six million persons, and slightly more than 100,000 newborn children are likely to be added to this group each year unless far-reaching preventive measures are discovered and employed.
Today, one out of every ten Americans has a family member who is developmental disabled. Developmental disability is four times more common than rheumatic heart disease and nine times more prevalent than cerebral palsy. It affects 15 times as many people as total blindness and 10 times as many children and adults as polio did before the Salk vaccine.

Who are People with Developmental Disability?

Developmental disability can be caused by any condition which impairs development of the brain before birth, during birth or in the early childhood years. Well over 250 causes have already been discovered, but they account for only about one-fourth of all known cases of developmental disability. In three-fourths of the cases, the specific cause remains unknown. Some of the most common causes include:

· **Genetic Irregularities—**These result from abnormality of genes inherited from parents, or from other disorders of the genes caused during pregnancy by infections, over exposure to x-rays and other factors. Inborn errors of metabolism which may produce developmental disability, such as PKU (phenylketonuria), fall in this category. Chromosomal abnormalities have likewise been related to some forms of developmental disability, such as Down's Syndrome.

· **Problems During Pregnancy—** Malnutrition, German measles, glandular disorders and many other illnesses of the mother during pregnancy frequently result in a child being born with developmental disability. Physical malformations of the brain or other organs originating in prenatal life may also result in retardation.

· **Problems at Birth—** Extraordinarily prolonged labor, pelvic pressure, hemorrhages-any birth condition of unusual stress-may injure the infant's brain. Likewise, any reduction in the supply of oxygen to the infant's brain during birth may impair mental development. Rh factor incompatibility between mother and child, if not promptly treated, can also lead to developmental disability.

· **Problems after Birth—**Childhood diseases such as whooping cough, chicken pox, measles, meningitis, scarlet fever encephalitis

and polio can damage the brain, as can accidents, such as a blow to the head. Glandular imbalance or malnutrition may prevent normal development, while substances such as lead and mercury can produce irreparable damage to the brain and nervous system.

· **Environmental Factors—**The President's Committee on Developmental Disabilities has concluded that 75 percent of our nation's citizens with developmental disability come from urban and rural poverty areas. Developmental disability can occur because of malnutrition, lead poisoning, disease producing conditions, inadequate medical care and other health hazards associated with poverty situations. Also, children in disadvantaged areas are likely to be deprived of many common day-to-day experiences of other youngsters. Research suggests that such under-stimulation can result in irreversible damage and can serve as a cause of developmental disability.

What are the Degrees of Developmental Disabilities?

About 89 percent of persons with developmental disability are mildly impaired and in many respects, quite similar to people without developmental disabilities. They differ primarily in race and degree of intellectual development. While still young, their disability is not readily apparent, and these children are not usually identified as disabled until they enter public school. With proper education and training, these individuals can enter the competitive labor market and the mainstream of daily community life.

Persons with moderate developmental disabilities comprise about six percent of the impaired and are more obviously handicapped. Their disability is usually apparent before school age. However, appropriate educational opportunities throughout the developmental years can prepare these individuals for satisfying and productive lives in the community.

The remaining five percent of people with developmental disabilities are severely or profoundly affected. In addition to obvious intellectual impairment, they frequently have other handicaps—cerebral palsy, epilepsy, blindness or deafness. Technological advances have demonstrated that most people who are severely and profoundly disabled can learn to care for their basic needs. They also can perform many useful work activities, with supervision, and can otherwise adapt satisfactorily to normal patterns of life.

Can Developmental Disabilities be Ameliorated?

All individuals who have developmental disabilities have the capacity to learn, develop and grow. The great majority can become economically productive, fully participating members of society.

All individuals who have developmental disabilities need the same basic services which other human beings need for normal development. These services include education, vocational preparation, health services of all types, recreational opportunities, religious services and many others. Unfortunately, many persons with these disabilities have been denied access to these services or have been provided with inappropriate services, often at exorbitant costs to their families.

In addition to basic generic services, many persons with developmental disability need specialized services to meet extraordinary needs. Examples include vocational rehabilitation, sheltered workshops, work activity centers, diagnostic and evaluation centers, day training, pre-school classes and

community based residential services (small group homes). There is a need for more of these opportunities and better facilities and services.

Can Developmental Disabilities be Prevented?

Scientific developments have led some authorities to conclude that 50 percent of developmental disability cases could be prevented if current knowledge were fully implemented. Unfortunately, many of the known preventive approaches are not yet in wide use.

There is an urgent need not only to apply what is already known, but to discover means of preventing those many causes of mental retardation for which effective prevention is still unknown. Examples of specific approaches to prevention include:

· Damage due to Rh-factor incompatibility can be prevented by blood exchange in the infant at the time of birth and special immunization.

· Quick treatment in cases of lead poisoning or, preferably, action to prevent children from eating lead-based paint chips, or being otherwise exposed to dangerous lead levels can also be effective in preventing some cases.

· Measles vaccine-developed to combat rubella– can help if widely used.

· Early detection and dietary treatment is effective in some forms of inborn errors of metabolism, such as PKU and galactosemia.

· Improved nutrition of pregnant women and young infants can reduce the dangers of developmental disability from malnutrition.

· Surgical techniques have proven effective in preventing developmental disability resulting from accumulation of creebrospinal fluid in the brain (hydrocephalus) and premature jusion of the cranial sutures (craniosynostosis).

· Better pediatric care, including antibiotics that control the high fever formerly associated with many dangerous children's diseases., also works to limit developmental disability.

AUTISM AND PERVASIVE DEVELOPMENTAL DISORDER

The Individuals with Disabilities Education Act (IDEA) defines autism as "a developmental disability significantly affecting verbal and non-verbal communication and social interaction, generally evident before age three, that adversely affects educational performance." Autism and pervasive developmental disorder are developmental disabilities that share many of the same characteristics. Usually evident by age three, autism and pervasive developmental disorder are neurological disorders that affect a child's ability to communicate, understand language, play and relate to others.

A diagnosis of autism is based on identification of a number of symptoms relating to social interaction, communication, and restricted repertoire of activities and interests. When fewer symptoms are identified, the child is diagnosed as having pervasive developmental disorder. Due to the similarity of behaviors associated with autism and pervasive developmental disorder, use of the term "pervasive developmental disorder" has caused some confusion among parents and professionals. However, the treatment and educational needs are the same for both diagnoses.

Some or all of the following characteristics may be observed in mild to severe forms:

- Communication problems (e.g., using and understanding language).
- Difficulty relating to people, objects and events.
- Unusual play with toys and other objects.
- Difficulty with changes in routine or familiar surroundings.
- Repetitive body movements or behavior patterns.

Children with autism or pervasive developmental disorder vary widely in abilities, intelligence, and behaviors. Some children do not speak; others have limited language that often includes repeated phrases or conversations. Persons with more advanced language skills tend to use a small range of topics and have difficulty with abstract concepts. Repetitive play skills, a limited range of interests, and impaired social skills are generally evident as well. Unusual responses to sensory information, for example, loud noises, lights, certain textures of food or fabrics, are also common.

LEARNING DISABILITIES AND ATTENTION DEFICIT DISORDER

The Individuals with Disabilities Education Act (IDEA) defines specific learning disabilities as follows:

> A disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor disturbance, or of environmental, cultural, or economic disadvantage.

Each person with a learning disability differs in the combination and severity of their limitations. The term "specific learning disabilities" encompasses a variety of permanent neurological conditions which influence how people of average or above average intelligence receive, store, organize, retrieve and use information through their senses and how they perform common tasks. Learning disabilities may cause difficulties in any of the following stages of information processing:

♦ **Data Input** is the process of recording in the brain information from the senses. The following problems may occur during this stage:

1. Visual-trouble receiving and/or accurately processing information from the sense of sight.
    a) distinguishing objects from background or other objects;
    b) distinguishing between two similar letters or objects;
    c) seeing things (such as letters on a page) in correct order;
    d) poor depth perception or distance judgment resulting in bumping into or falling over objects.

2. Auditory-difficulty in accurately receiving information from the sense of hearing. Specific examples:
    a) distinguishing sound from background noise;
    b) hearing differences between two sounds;
    c) hearing sounds in correct order; and
    d) keeping up with the flow of conversation.

3. Tactile-difficulty in receiving information through sense of touch. Specific examples:
    a) feeling the difference between two similar objects;
    b) judging appropriate pressure needed to manipulate object without breaking it.

♦ **Integration** is the process of interpreting information through sequencing, abstraction and organization. Difficulties in sequencing involve reversing the order of letters in words and an inability to memorize lists in order, such as the days of the week. Problems with abstraction affect a person's

ability to infer meaning from a story or conversation. The inability to organize prevents a person from integrating and relating new information to what has been previously learned.

♦ **Memory** is a storage of information for later retrieval. Most memory disabilities affect short-term memory only, resulting in the person's need for additional repetitions of information.

1. Language disabilities tend to involve situations where communication is required, such as being asked a specific question, rather than spontaneous conversation.

2. Motor difficulties are classified as either gross motor (involving large muscle use) or fine motor. Gross motor difficulties may result in poor coordination and clumsiness, and problems with such activities as running, biking and climbing. Fine motor difficulties affect the ability to write, sew or do other "precision" work.

Learning disabilities are a life-long condition, which do not disappear with age, though they may be modified. They affect a person's personality and social development as well as ability to acquire knowledge. While a learning disability is recognized most often in a learning situation, it can affect many areas of life, including relationships with family and friends, self-image, confidence in handling routine situations, and success in such non-academic pursuits as sports and dancing. Some people with learning disabilities may observe less in their social environment, may misperceive more, may not learn as easily from experience, and may exhibit immaturity and social ineptness.

The specific causes of learning disabilities are unknown, although they are believed to be neurological in origin, normally manifested during the developmental stage. Learning disabilities also may be genetic, as there is evidence that they run in families. There is no cure for learning disabilities. However, correction or management is possible by addressing the educational, physiological, psychological and medical needs of the individual. An appropriate action plan which addresses specific needs, fosters individual strengths, and implements practical strategies can foster an individual's participation at school, home, church, and in the community. Boundaries and limits should be set and demands should be modest and appropriate. Empowering the person to experience success in any area of life will aid in fostering positive self-esteem and future success in other areas as well.

Many children and adults with learning disabilities have difficulty in school and work due to misdiagnosis and mistreatment of their disability. They struggle to compete, while dealing with situations and information which to them are incomprehensible. As they begin to fall behind in school and related activities, they realize that something is wrong but are uncertain about how to respond. Because learning disabilities are hidden they often go unrecognized or undiagnosed. This causes misunderstandings, and often the person is labeled as "slow," "unmotivated," "emotionally disturbed," or as an "underachiever." The inclusion of learning disabilities in the definition of "disability" in P.L. 94-142, and subsequently the Individuals with Disabilities education Act (IDEA) and the Rehabilitation Services Administration's 1981 decision to accept specific learning disabilities as medically recognizable have improved their detection and treatment.

Attention Deficit Hyperactivity Disorder (ADHD)

In recent years a new classification has been developed to address behaviors, which in an earlier time were not perceived as being a disability. Today there is a focus on attention deficit hyperactivity disorder (ADHD, previously known simply as ADD) and it is being observed by more people to explain certain behaviors in children. While these behaviors are exhibited by many children at one time or another, those students classified as having attention deficit hyperactivity disorder habitually manifest these behaviors.

Attention deficit hyperactivity disorder is a developmental disability estimated to affect between 3-5% of all children. It is characterized by inattentiveness, impulsivity and in many cases, but not all, restlessness or hyperactivity which results in many of the following behaviors:

- Is easily distracted.
- Difficulty following instructions and concentrating.
- Leaves one unfinished task for another task.
- Doesn't seem to listen.
- Loses needed items, such as books, clothing.
- Has difficulty waiting for his/her turn.
- Acts without thinking.
- Often interrupts.
- Seems to fidget constantly.
- Has difficulty remaining seated or playing quietly.
- Talks excessively.

An individual with attention deficit hyperactivity disorder may also have learning disabilities, and often is lacking in social skills which results in immature behavior and demands for attention. The individual may also get frustrated easily, be overly sensitive, have difficulty expressing feelings or accepting responsibility for behavior, and may get into frequent fights or arguments.

The causes of attention deficit hyperactivity disorder are unknown, though they are thought to be genetically transmitted in many cases and a result of a chemical imbalance or deficiency in certain neurotransmitters. Thus, it is believed that attention deficit hyperactivity disorder is a neurologically-based medical problem rather than a result of poor parenting or diet. There is no cure for attention deficit hyperactivity disorder, but treatment plans which include a combination of behavior modification, counseling, medication and educational planning can assist the individual to interact more appropriately with his or her environment.

Individuals with these diagnoses can be assisted to fulfill their God-given potential when their limitations are addressed with patience, compassion and the appropriate services mentioned above. These individuals, as all people with disabilities, have gifts which can greatly enhance the Faith Community.

HEARING LOSS AND DEAFNESS

The term "deafness" can refer to a broad spectrum of hearing loss. Assessment of individual needs and preferences is essential.

10% of the population experiences some degree of hearing loss.

The degree of hearing loss and the onset of hearing loss play an important part in the language development of a person with a hearing loss.

Definitions:

Hearing Impaired	People with all types of hearing loss from slight to profound
Hard of Hearing	Hearing loss that limits functional communication.
Deaf	Condition in which sound, including speech have no meaning in ordinary life, even with the help of a hearing aid.
Pre-lingual	Deafness occurs prior to the development of speech and language.
Post-lingual	Deafness occurs after the development of speech and language.
Prevocational	Deafness, which occurs before age 19.

Classes of Hearing Loss:

Mild - This may pass unnoticed or may have slight difficulty hearing distant speech or background noises. Psychologically, however, it is the impaired awareness and the environmental detachment which are of most importance. The extent of the difficulty experienced will be dependent on how great the loss is, distance from the sound source and the quality of the sound.

Moderate - Generally understands conversational speech within a range of three to five feet. Socialization is definitely affected. The use of amplification makes conversation possible, but is essentially limited to one person or a small group. The person experiences much detachment and seeks social relationships with others having similar degrees of deafness.

Severe - Sounds must be loud and distance small for conversation to be heard with the help of technology. Person will have considerable difficulty unless conversation is directed exclusively to him or her.

Profound - Unable to hear sound even with the help of technology.

Communication Methods

1. Oral communication—person will speech read.

2. American Sign Language (ASL) - native language of most pre-lingual deaf persons. ASL cannot be spoken or written. ASL is a visual-gesture language.

3. Total Communication—person will sign and voice at the same time.

4. Signed English - a term used by some to refer to signing that combines the grammatical structure of English and the signs of ASL.

5. Dactylology—generally refers to finger-spelling, but has been used by some to include sign as well.

6. Devices—Telephone Communication Device for the Deaf (TDD/TTY). Text telephone/ pagers that act as cell phones for deaf persons. These devices allow conversations to be typed back and forth and read on the display screen. Video Relay systems that allow deaf persons to communicate directly with an interpreter via computer or television screens.

7. Paper and pen—written communication.

8. Natural gestures—pointing to an item, shrugging shoulders, waving hand, handshake.

9. Qualified interpreter - when necessary.

HEARING LOSS/DEAFNESS: SOME HELPFUL POINTS

- Talk naturally, neither too fast nor too slow.
- Use a phrase or a sentence, not single words. Establish the topic first.
- Avoid repeating the same thing in the same way. Change it.
- Discourage the analysis of every word.
- Encourage habits of synthesis and intuition by praising the person when he employs them.
- Show confidence in the ability of the students to understand, through some sort of praise.
- Face the person in such a way so as to permit him to lip-read without strain.
- Avoid glare from behind. It makes it difficult to read the lips. The light, either daylight or artificial, should be on the speaker's face.
- Avoid shouting. This may impair the satisfactory relationship between speaker and lip reader so essential to successful communication, especially when the person is hard of hearing.
- Be natural. Speak distinctly and do not slow down the tempo too suddenly.
- Enunciate clearly. Even though the person who is deaf cannot hear the voice, the added effect made may produce more accurate speech. Beware of overemphasizing speech, exaggerated movements.
- If a person who is deaf is within hearing persons, an effort should be made to make him feel a part of the group. Speak to him. If speech doesn't suffice, then use a pad and pencil, gestures and signs.
- Face a person who is deaf when speaking to him, as standing at an angle may make speech reading difficult.
- The voice should not be raised to an unusual pitch, but a moderate increase in intensity may be necessary.
- If what is said is not understood, rephrase the statement immediately. When the key words are not understood, there is no comprehension. The key word may not show on the lips. There are many words such as uncle, cousin, sister, dinner, that have no lip movements. Contrast these with father, mother, brother, beautiful, love. These are "outside" words, and are readily seen on the lips.

GUIDELINES FOR HELPING DEAF-BLIND PERSONS

1. When you approach a deaf-blind person, let him know—by a simple touch—that you are near.

2. Make positive but gentle use of any means of communication you adopt.

3. Work out with him a simple but special signal for identifying yourself to him.

4. Learn and use whatever method of communication he knows, however elementary. If a more adequate method might be valuable to him, help him learn it.

5. Always be sure the deaf-blind person understands you, and be sure that you understand him.

6. Encourage him to use his voice if he has speech, even if he knows only a few words.

7. If there are others present, let him know when it is appropriate for him to speak.

8. Always inform him of his whereabouts.

9. Always tell him when you are leaving, even if it is only for a brief period. See that he is comfortably and safely situated. If he is not sitting, he will need something substantial to touch in your absence. Place his hand on it before leaving. Never abandon a deaf-blind person in unfamiliar surroundings

10. When with a deaf-blind person, keep sufficiently close so that, by physical contact, he will know you are there.

11. In walking, let him take your arm, never push him ahead of you.

12. Make use of a simple set of signals to let him know when he is about to ascend or descend a flight of stairs, walk through a doorway, board a vehicle. A deaf-blind person holding your arm can usually sense any change in place or direction.

13. Rely on your natural courtesy, consideration, and common sense. Occasional difficulties in communication are only to be expected.

PHYSICAL DISABILITIES

Physical Disabilities can affect a person's ability to move about, to use arms and legs effectively, to swallow food, and to breathe independently. They may also affect other capacities such as vision, cognition, speech, language, hearing, and bowel control. The Individuals with Disabilities Education Act (IDEA) uses the term **orthopedically impaired** to describe students with physical disabilities and the term **other health impaired** to describe students with health disabilities.

CEREBRAL PALSY

Cerebral Palsy (CP) is a disability resulting from damage to the brain either before, during, or after birth. Evidenced by motor problems, general physical weakness, lack of coordination, and speech disorders, the syndrome is not contagious, progressive, or remittent. Its seriousness and overall impact can range from very mild to very severe. Individuals with cerebral palsy have poor coordination, irregular movement patterns, and poor balance, or a blend of these characteristics (Miller & Bachrach, 1995). There are three major types of CP: spastic - stiff and difficult movement; athetoid - involuntary and uncontrolled movement; ataxic – disturbed sense of balance and depth perception" (United Cerebral Palsy, 1997).

CP is a complicated and perplexing condition. Individuals with CP are likely to have mild to severe problems in non-motor areas of functioning, including hearing impairments, speech and language disorders, intellectual deficits, visual impairments, and general perceptual problems. Because of the multifaceted nature of this condition, many individuals with CP are considered to be multi-disabled. Thus, CP cannot be characterized by a set of homogeneous symptoms; it is a condition in which a variety of problems may be present in differing degrees of severity.

SPINA BIFIDA

Spina Bifida is a congenital disability characterized by an abnormal opening in the spinal column. It originates in the first days of pregnancy, often before a mother even knows that she is expecting a child. Through the process of cell division and differentiation, a neural tube forms in the developing fetus. At about 26-27 days this neural tube fails to completely close, for reasons not fully understood. This failure results in various forms of spina bifida, frequently involving some paralysis of various portions of the body, depending on the location of the opening (Sujansky, Stewart, & Manchester, 1997). It may or may not influence intellectual functioning.

SPINAL CORD INJURY (SCI)

Spinal cord injury occurs when the spinal cord is traumatized or severed. Trauma can result through extreme extension or flexing from a fall, an automobile accident, or a sports injury. The cord can be severed through the same types of accidents, although such occurrences are extremely rare. Usually in such cases, the cord is bruised or otherwise injured, after which swelling and, within hours, bleeding often occur. Gradually a self-destructive process ensues, in which the affected area slowly deteriorates and the damage becomes irreversible (Baskin, 1996).

The overall impact of injury on an individual depends on the site and nature of the insult. If the injury occurs in the neck or upper back, the resulting paralysis and effects are usually quite extensive. If the injury occurs in the lower back, paralysis is confined to the lower extremities. Like individuals with spina bifida, loss of voluntary bowel and bladder function may result from the injuries sustained in a SCI. For a brief review of the areas affected by different paralytic conditions, see Table below.

Spinal cord injuries usually occur in situations that inflict other serious damage to the individual. Accompanying injuries include head trauma (15%0, fractures of some portion of the trunk (20%), and significant chest injuries (15%) (Guiterrez, Vulpe, & Young, 1994).

The physical characteristics of spinal cord injuries are similar to those of spina bifida myelomeningocele except that hydrocephalus does not tend to develop. The three main types of spinal cord injuries are: **paraplegia, quadriplegia,** and **hemiplegic.** Note, however, that these terms are broad descriptions of functioning and are not precise enough to accurately convey an individual's actual level of motor functioning.

TABLE

Description	Affected Area
Monoplegia	One limb
Paraplegia	Lower body and both legs
Hemiplegic	One side of the body
Triplegia	Three appendages or limbs, usually both legs and one arm.
Quadriplegia	All four extremities and usually the trunk.
Diplegia	Legs more affected than arms
Double Hemiplegia	Both halves of the body, with one side more affected than the other.

MUSCULAR DYSTROPHY

Definitions and Concepts

Muscular dystrophy is a progressive disorder that affects the muscles of the hips, legs, shoulders and arms, which over time causes individuals with this disease to lose their ability to walk and to use their arms and hands effectively. The loss of ability occurs as fatty tissue gradually replaces muscle tissue. Heart muscle may also be affected, resulting in symptoms of heart failure. There are different forms of muscular dystrophy. The seriousness of the various dystrophies is influenced by heredity, age of onset, the physical location and nature of onset and the rate at which the condition progresses.

Duchenne type muscular dystrophy (DMD) is the most severe form of dystrophy. DMD generally manifests itself between the ages of 2 and 5. Early in the second decade of life, individuals with DMD must use wheelchairs to move from place to place. By the second or early in the third decade of life, young adults with DMD die from respiratory insufficiency or cardiac failure (Kelly, 1996).

DMD is first evidenced in the pelvic girdle, although it sometimes begins in the shoulder girdle muscles. With the passage of time, individuals begin to experience a loss of respiratory function and are unable to cough up secretions that may result in pneumonias. Also, severe spinal curvature develops over time with wheelchair use; this condition can be prevented through spinal fusion.

Interventions

There is no known cure for muscular dystrophy. The focus of treatment is maintaining or improving the individual's functioning and preserving his or her ambulatory independence for as long as possible. The first phases of maintenance and prevention are handled by a physical therapist, who works to prevent or correct contractures (a permanent shortening and thickening of muscle fibers). As the condition becomes more serious, treatment generally includes prescribing supportive devices, such as walkers, braces, night-splints, surgical corsets and hospital beds. Eventually, the person with muscular dystrophy will need to use a wheelchair.

MULTIPLE SCLEROSIS

MS is thought to be an autoimmune disease that affects the central nervous system (CNS). The CNS consists of the brain, spinal cord, and the optic nerves. Surrounding and protecting the nerve fibers of the CNS is a fatty tissue called **myelin,** which helps the nerve fibers conduct electrical impulses.

In MS, myelin is lost in multiple areas, leaving scar tissue called sclerosis. These damaged areas are also known as plaques or lesions. Sometimes the nerve fiber itself is damaged or broken.

Myelin not only protects nerve fibers, but makes their job possible. When myelin or the nerve fiber is destroyed or damaged, the ability of the nerves to conduct electrical impulses to and from the brain is disrupted, and this produces the various **symptoms** of MS.

People with MS can expect one of four clinical courses of disease, each of which might be mild, moderate or severe.

Relapsing-Remitting Characteristics:

People with this type of MS experience clearly defined flare-ups (also called relapses, attacks, or exacerbations). These are episodes of acute worsening of neurologic function. They are followed by partial or complete recovery periods (remissions) free of disease progression.

Frequency: Most common form of MS at time of initial diagnosis. Approximately 85%.

Primary-Progressive Characteristics:

People with this type of MS experience a slow but nearly continuous worsening of their disease from the onset with ho distinct relapses or remissions. However, there are variations in rates of progression over time, occasional plateaus and temporary minor improvements.

Frequency: Relatively rare. Approximately 10%.

Secondary-Progressive Characteristics:

People with this type of MS experience an initial period of relapsing-remitting disease, followed by a steadily worsening disease course with or without occasional flare-ups, minor recoveries (remissions), or plateaus.

Frequency: 50% of people with relapsing-remitting MS developed this form of the disease within 10 years of their initial diagnosis, before introduction of the "disease modifying" drugs. Long-term data are not yet available to demonstrate if this is significantly delayed by treatment.

Progressive-Relapsing Characteristics:

People with this type of MS, experience a steadily worsening disease from the onset, but also have clear acute flare-ups (attacks or relapses), with or without recover. In contrast to relapsing-remitting MS, the periods between relapse are characterized by continuing disease progression.

Frequency: Relatively rare. Approximately 5%.

SEIZURE DISORDERS

Seizures are one of the most common disorders of the nervous system in children. Seizures may occur as a symptom of a disorder or disease or as a chronic condition of the nervous system. The chronic condition is known as seizure disorder or **epilepsy.**

Seizures occur in approximately 5 children out of 1,000 (Epilepsy Foundation of America, 1994; Hauser & Hesdorffer, 1990), and the majority of those who develop seizure disorders will do so before age 20 (Holmes, 1992). Seizure disorders are found approximately 20 times more frequently in individuals with disabilities than in those without. Most people think of a person having a seizure as someone stiff and shaking uncontrollably on the ground, but there are many types of seizures with many different characteristics, prognoses, treatments and educational implications.

Throughout history, misconceptions and prejudices about people with seizure disorders have been common. Often these people were considered to be possessed by evil spirits or by a divine presence. In primitive history, seizures were often attributed to evil spirits, and holes were cut through the brain to presumably let the evil spirits escape. Hippocrates wrote about seizure disorders 2,000 years ago in a work titled "The Sacred Disease." During the Middle Ages, individuals who had seizures were burned at the stake as witches or were thought to be possessed (Temkin, 1971); before the 20th century, they were frequently locked away in insane asylums or jails because they were considered insane. Because seizure disorders were thought to be inherited, mandatory sterilization of individuals with seizure disorders was required by law, which remained in effect in several states until 1971.

Even today, many misconceptions and social prejudices regarding individuals with seizure disorders persist. Classmates and adults who are not taught about the condition may fear being around a child with a seizure disorder. Teachers who lack understanding may not recognize certain behaviors as seizures or may not know what to do when a child has a convulsive seizure (a violent, involuntary contraction of the voluntary muscles). As the child with seizure disorders grows older, he or she may be denied access to certain extracurricular activities. Later, employment opportunities may be missed. It is clearly important that the teacher understand the **etiology**, characteristics, detection, treatment, course, and educational implications of seizure disorders.

Description of Seizure Disorders

Seizures

A seizure can be defined as a sudden, involuntary, time-limited disruption in the normal functions of the central nervous system, which may be characterized by altered consciousness, motor activity, sensory phenomena, or inappropriate behavior (Berkow, 1992; Holmes, 1992). Seizures may exhibit only one of these characteristics or different combinations, depending on the type.

Seizure Disorder/Epilepsy

Seizure disorder, also known as epilepsy, refers to a chronic condition in which the person has recurring seizures. A seizure that occurs as a result of a short-term condition, such as meningitis or a fever, is not considered symptomatic of a seizure disorder. At least two seizures that are unrelated to a short-term underlying cause must have occurred to be considered a seizure disorder.

CELIAC DISEASE and CATHOLIC COMMUNION

Ask and it will be given to you; seek and you will find; knock and the door will be opened to you. For everyone who asks, receives; and the one who seeks, finds; and to the one who knocks, the door will be opened. (Matthew7:7)

Catholic Communion and Celiac Disease

Catholics with celiac disease face a special challenge when it comes to the Church and the Holy Eucharist. Canon law states that the host must be made of wheat and water and contain no foreign materials or impurities. From the time that the Lord Jesus took bread and wine and told his disciples "Do this in memory of me," the Roman Catholic Church has faithfully protected the integrity of the Eucharist by only allowing wheat flour and water for the bread and pure grape juice for the wine to be used in the sacred liturgy. Catholics with celiac cannot safely share in the Eucharist using traditional altar breads.

Celiac Disease

Celiac disease, or celiac sprue, is an inherited auto-immune condition that is estimated to affect 1 in every 133 people in the United States. The disease is an immune system malfunction that causes the body to attack the lining of the small intestine as well as other organs. Damage is triggered by exposing the immune system to certain proteins, commonly called gluten, which are found in cereal grains wheat, rye, and barley. Celiac disease is life-long; there is no cure. Damage to the small intestine occurs every time gluten is consumed, regardless of whether symptoms are present. The only treatment is to adopt what is called the gluten-free diet, which completely eliminates the offending proteins from their diet. To learn more about celiac disease: http://celiac.org OR http://www.gluten.net/celiac.html

Holy Communion Options

The celebration of the Holy Eucharist and the reception of Holy Communion have been called the very source and summit of the Christian life. Every Catholic in good standing has the right to receive Holy Communion (Canon 843). The Church has been studying the issue of Holy Communion for people with celiac disease very carefully. In Europe and other parts of the world, Catholics with celiac disease have used wheat starch based low-gluten hosts for Holy Communion for years. In these parts of the world, medical standards are different, and specially treated wheat starch is considered to be an acceptable part of the gluten-free diet treatment of celiac disease. The clinical outcome for celiac patients in these other areas has not been shown to be significantly different from that seen in patients in North America who use a more stringent version of the gluten-free diet. In keeping with Sacred Tradition, the Church has stipulated that completely gluten-free hosts are not valid matter for the celebration of the Eucharist. However, the Church has approved the use of low-gluten wheat starch based hosts provided that "they contain the amount of gluten sufficient to obtain the confection of bread without the addition of foreign materials and without the use of procedures that would alter the nature of bread."

The doctrine of concomitance teaches that under either species of bread or wine, the whole of Christ is received. **Catholics with celiac are therefore encouraged to receive the Eucharist in the form of the Precious Blood.** This is more easily accomplished in parishes that routinely offer Holy Communion under both species; however Catholics with celiac have the right to request Holy

Communion in the form of consecrated wine from a separate chalice regardless of whether the Precious Blood is offered to the rest of the faithful present at a given celebration of Mass. Catholics with celiac are usually no longer required to present medical certification documenting their condition when they request accommodation for Holy Communion from their pastor. Their pastor generally does not need specific permission from their bishop in order to meet the needs of their celiac parishioner.

Consecrated Wine

Holy Communion under the form of wine is safe, provided that the chalice is free of any particles of wheat. Celiac patients should not receive from the priest's chalice because of the fermentation, a tiny fraction of the regular wheat host that is added to his chalice during the fraction rite. An easy way to avoid problems is for them to receive from a chalice used only by the celiac patient and that is in some way distinct so that it will not be confused with the other chalices on the altar table. No particle of the consecrated host should be placed in this chalice. A distinctive chalice also reminds the priest and extraordinary ministers of Holy Communion that a parishioner with special needs is present.

The particular arrangements for receiving Holy Communion should be discussed with the celebrant and extraordinary ministers of Holy Communion before mass so that all parties involved are comfortable with the agreed-upon procedure. Every effort should be made to enhance the feeling of inclusion of the person suffering from celiac at the Eucharist.

Catholics with celiac may choose to receive consecrated wine at a regular communion station if their parish offers communion under both species. There is greater risk for contamination using this option, but it has the benefit of allowing them to receive Holy Communion with the rest of the community without feeling isolated or singled out for special treatment. When using this option, it makes good sense for them to be near the "front of the line" when receiving communion to minimize the risk of cross-contamination.

In the case of Catholics affected by celiac and by alcoholism or other conditions which prevent the ingestion of even the smallest amount of consecrated wine, the use of mustum is allowed. Mustum is a grape juice in which fermentation has been suspended so that there is very minimal alcohol content.

Low-Gluten Hosts

A special, extremely low-gluten host has been developed for Catholics with celiac by the *Benedictine Sisters of Perpetual Adoration*. These hosts are produced and packaged in a dedicated environment. They have been checked for gluten by the American Institute of Baking using the ELISA (Enzyme-Linked Immunosorbent Assay) method. This analysis determined that the gluten level in the low-gluten hosts was less than 0.01%.

The low-gluten hosts should be placed in a clean pyx (a small container used to carry the Eucharist to the sick). A pyx is inexpensive and may be purchased at a religious supplies store. Preferably, the pyx containing the low-gluten hosts should not be placed in the ciborium with the other hosts and should be closed after consecration. There is risk of contamination from crumbs or dust from the regular hosts falling into an open pyx. The risk of cross contamination from hands during the administering

of communion with the low-gluten host is very small. However, it makes good sense for the person with celiac to be near the "front of the line."

Spiritual Communion

"Spiritual Communion" is an act expressing what was described by St. Thomas Aquinas as "an ardent desire to receive Jesus in the Most Holy Sacrament and in lovingly embracing Him." We ask our Lord to come to us in the same way He would if we were able to receive the sacrament. Spiritual communion is always available and might be especially appropriate when traveling or attending Mass outside your parish.

Suggested guidelines for persons with Celiac Disease who wish to receive low-gluten host

The decision to receive the low-gluten host should be based on the individual's current health, how well the gluten-free diet is being followed, and the comfort level of the person and his or her physician.

1. Establish that the lgG and lgA antigliadins and tTg are well within the normal range. If not, taking the host is not an option until they are.
2. Discuss receiving the host with your doctor and schedule a follow-up appointment in six months.
3. Work out an arrangement with your priest. There is no need to consume the entire host; taking only 1/4 host is acceptable.
4. Check levels of the antibodies again in six months. If they are higher, evaluate how much of the host you are taking or discontinue use. If they are the same, continue using the same amount, and return for testing in another six months.

Benedictine Sisters of Perpetual Adoration

The Sisters' website is at: http://www.benedictinesisters.org

There is an order form located at: http://www.benedictinesisters.org/altarbread/orderform.html

Look for "Low Gluten Breads" at the bottom of the form.
Their phone number is: 1-800-223-2772

Catholic Celiac Society

The Catholic Celiac Society has been organized to educate Catholics who have celiac about their options for Holy Communion as provided for by canon law and the U.S. Conference of Catholic Bishops; to Inform Catholic clergy and lay ministers about the needs of Catholic with celiac in their dioceses and parishes; and to reconcile those who have left the Church because of lack of understanding, exclusion from the Eucharist, and isolation from their church community.
http://www.catholicceliacs.org

VISION LOSS and BLINDNESS

Definitions

The term vision loss describes a condition experienced by people with a wide range of educational, social and medical needs directly related to a partial or complete loss of sight. This definition encompasses people who have never had any visual function, those who had normal vision for some years before becoming gradually or suddenly partially or totally blind, those with [disabilities] in addition to the visual loss, those with selective impairments of parts of the visual field, and those with a general degradation of acuity across the visual field.
(Warren, 1989, p.155)

A variety of terms are used to describe levels of vision loss, a diversity that has created some confusion among professionals in various fields of study. The rationale for the development of various definitions is directly related to their intended use. For example, eligibility for income tax exemptions or special assistance from the American Printing House for the Blind requires that individuals with vision loss qualify either under one of two general subcategories: blind or partially sighted (low vision).

BLINDNESS

The word *blindness* has many meanings. In fact, there are over 150 citations for **blind** in an unabridged dictionary.

Legal Blindness as defined by the Social Security Administration is a visual acuity of 20/200 or worse in the best eye with best correction, as measured on the **Snellen test**, or a visual field of 20% or less. The definition of legal blindness includes a wide range of visual ability that involves both acuity and field of vision (Corn & Koenig, 1966.)

Visual Acuity is determined by the use of an index that refers to the distance from which an object can be recognized. The person with normal eyesight is defined as having 20/20 vision. However, if an individual is able to read at 20 feet what a person with normal vision can read at 200 feet, then his or her visual acuity would be described as 20/200. Most people consider those who are legally blind to have some light perception; only about 20% are totally without sight.

A person is also considered blind if his or her field of vision is limited at its widest angle to 20 degrees or less. A restricted field of vision is also referred to as **tunnel vision**, pinhole vision or tubular vision. A restricted field of vision severely limits a person's ability to participate in athletics, read, or drive a car.

Educational Blindness

Blindness can also be characterized as an educational disability. Educational definitions of blindness focus primarily on students' ability to use vision as an avenue for learning. Children who are unable to use their sight and rely on other senses, such as hearing and touch are described as educationally blind.

Educational Blindness in its simplest form, may be defined by whether vision is used as a primary channel of learning. Regardless of the definition used, the purpose of labeling a child as educationally blind is to ensure that he or she receives an appropriate instructional program. This program must assist the student who is blind in utilizing other senses as a means to succeed in a classroom setting and in the future as an independent productive adult.

Partial Sight (Low Vision)

People with partial sight or low vision have a visual acuity greater than 20/200 but not greater than 20/70 in the best eye after correction. The field of education also distinguishes between being blind and partially sighted when determining the level and extent of additional support services required by a student. The term **partially sighted** describes people who are able to use vision as a primary source of learning.

A vision specialist often works with students with vision loss to make the best possible use of remaining sight. This includes the elimination of unnecessary glare in the work area, removal of obstacles that could impede mobility, use of large-print books, and use of special lighting to enhance visual opportunities. Although many children with low vision do use printed materials and special lighting in learning activities, some use **braille** because they can see only shadows and limited movement. These children require the use of tactile or other sensory channels to gain maximum benefit from learning opportunities (Barraga & Erin, 1992).

Two very distinct positions have been formed regarding individuals who are partially sighted and their use of residual vision. The first suggests that such individuals should make maximal use of their functional residual vision through the use of magnification, illumination and specialized teaching aids (e.g., large-print books and posters), as well as any exercises that will increase the efficiency of remaining vision. This position is contrary to the more traditional philosophy of sight conservation or sight saving, which advocates restricted use of the eye. It was once believed that students with vision loss could keep what sight they had much longer if it was used sparingly. However, extended reliance on residual vision in conjunction with visual stimulation training now appears to actually improve a person's ability to use sight as an avenue for learning.

Muscle Disorders

Muscular disorders of the visual system occur when one or more of the major muscles within the eye are weakened in function, resulting in a loss of control and an inability to maintain tension. People with muscle disorders cannot maintain their focus on a given object for even short periods of time. The three types of muscle disorders are nystagmus (uncontrolled rapid eye movement), strabismus (crossed eyes), and amblyopia (an eye that appears normal, but does not function properly).

Nystagmus

Is continuous, involuntary, rapid movement of the eyeballs in either a circular or side-to-side pattern.

Strabismus

Occurs when the muscles of the eyes are unable to pull equally, thus preventing the eyes from focusing together on the same object. Internal strabismus **(estropia)** occurs when the eyes are pulled inward toward the nose; external strabismus **(exotropia)** occurs when the eyes are pulled out

toward the ears. The eyes may also shift on a vertical plane (up or down), but this condition is rare. Strabismus can be corrected through surgical intervention. Persons with strabismus often experience a phenomenon known as double vision, since the deviating eye causes two very different pictures coming to the brain. To correct the double vision and reduce visual confusion, the brain attempts to suppress the image in one eye. As a result, the unused eye loses its ability to see. This condition, known as:

Amblyopia
Can also be corrected by surgery or by forcing the affected eye to focus by covering the unaffected eye with a patch.

Receptive Eye Problems
Disorders associated with the receptive structures of the eye occur when there is a degeneration of or damage to the retina and the optic nerve. These disorders include optic atrophy, retinitis pigmentosa, retinal detachment, retrolental fibroplasia and glaucoma.

Optic Atrophy
Is a degenerative disease that results from the deterioration of nerve fibers connecting the retina to the brain.

Retinitis Pigmentosa
The most common hereditary condition associated with loss of vision, appears initially as night blindness and gradually degenerates the retina. Eventually, it results in total blindness.

Retinal Detachment
Occurs when the retina separates from the choroid and the sclera. This detachment may result from disorders such as glaucoma, retinal degeneration, or extreme myopia. It can also be caused by trauma to the eye, such as a boxer's receiving a hard right hook to the face.

Retinopathy of Prematurity (ROP)
Formerly known as retrolental fibroplasia, is one of the most devastating eye disorders in young children. It occurs when too much oxygen is administered to premature infants, resulting in the formation of scar tissue behind the lens of the eye, which prevents light rays from reaching the retina. ROP gained attention in the early 1940s, with the advent of improved incubators for premature infants. These incubators substantially improved the concentration of oxygen available to the infant but resulted in a drastic increase in the number of children with vision loss. The disorder has also been associated with neurological, speech and behavior problems in children and adolescents. Now that a relationship has been established between increased oxygen levels and blindness, premature infants can be protected by careful control of the amount of oxygen received in the early months of life.

Age-related Macular Degeneration (AMD)
Age-related macular degeneration is an eye disease that is present to at least a mild degree in millions of older Americans. It is a leading cause of vision loss in this country. AMD affects the macula, a small portion of the retina. The retina is the light-sensing nerve tissue that lines the inside

of the eye. All parts of the retina contribute to sight, but only the macula can provide the sharp, straight-ahead vision that is needed for driving and reading small print.

As a person ages, harmful changes may occur in this small but important area of the retina, causing difficulties in reading and other tasks that require good central vision. Scientists do not know why these macular changes occur. But aging evidently plays a major role in the process. That is why it is known as age-related, or senile, macular degeneration.

Although AMD is a leading cause of vision loss, it is important to know that the majority of people with AMD continue to have almost normal vision throughout their lives. Even those who are severely affected do not lose all their sight, but retain enough to move about independently and make use of helpful devices called low vision aids. For a limited number of people who develop a rapidly worsening form of AMD that seriously endangers vision, there is a sight-saving treatment developed through research.

Usually, AMD does not develop until a person is 65 or older. But a few people are affected by the disease while still in their forties and fifties. A person's chances of developing AMD are greater than average if he or she has a near relative with the disease. Scientists are now trying to learn what other factors might place a person at risk for AMD.

Signs and Symptoms

Most people with AMD have a form of the disease that develops very slowly. It is called the "dry" form. In it, tiny yellowish deposits called drusen develop beneath the macula. Also, the layer of light-sensitive cells in the macula becomes thinner as some cells break down. These changes typically cause a dimming or distortion of vision that people find most noticeable with they try to read.

Generally, if one eye has dry AMD, the other eye will also have some signs of the condition. Thus the person with dry AMD may eventually have visual problems in both eyes. However, the dry form of AMD rarely causes total loss of reading vision.

A much greater threat of vision loss arises when the dry form of AMD gives way to the "wet" or neovascular form of the disease. This condition arises in a small percentage of AMD patients. In it, new blood vessels grow beneath the macula. These abnormal vessels leak fluid and blood, causing the light-sensitive cells near them to sicken and die. This process generally produces a marked disturbance of vision in the affected eye: Straight lines look wavy, and later there may be blank spots in the field of vision.

If the leakage and bleeding from new vessels continues, much of the nerve tissue in the macula may be killed or injured within a period of a few weeks or months. Such damage cannot be repaired, because the nerve cells of the macula do not grow back once they have been destroyed.

Although only a small percentage of people with AMD develop the neovascular form, they make up the vast majority of those who experience serious vision loss from AMD.

Macular Degeneration

Macular degeneration is the leading cause of central vision loss among older people. It results from changes to the macula, a portion of the retina, responsible for clear, sharp vision, and located on the inside back wall of the eye.

The macula is many times more sensitive than the rest of the retina and without a healthy macula, seeing detail or vivid color is not possible.

There are several causes for macular degeneration. In one type, the tissue of the macula becomes thin and stops working well. This type is thought to be a part of the natural aging process in some people.

In another, fluids from newly formed blood vessels lead into the eye and cause vision loss. If detected early, this condition can be treated with laser therapy, but early detection and prompt treatment is vital in limiting damage.

Macular degeneration develops differently in each person, so the symptoms may vary. But, some of the most common symptoms include:

- A gradual loss of ability to see objects clearly
- Distorted vision. Objects appear to be the wrong size or shape or straight lines appear wavy or crooked.
- A gradual loss of clear color vision
- A dark or empty area appearing in the center of vision

These symptoms may also indicate other eye health problems, so if you are experiencing any of these, you should contact your doctor of optometry immediately.

In a comprehensive eye examination, your doctor will perform a variety of tests to determine if you have macular degeneration or another condition causing your symptoms.

Unfortunately, there is no way to restore central vision damaged by macular degeneration. However, since macular degeneration does not damage side vision, low vision aids such as telescopic and microscopic special lenses, magnifying glasses and electronic magnifiers for close work, can be prescribed to help make the most of remaining vision. Often, a person, with adaptation, can cope well and continue to do most things they were accustomed to doing.

Remember! Early detection of macular degeneration is the most important factor in determining if you can be treated effectively. Use the simple vision check on the other side of this sheet and maintain a regular schedule of optometric examinations to help protect your vision.

CLASSIFICATIONS OF VISION LOSS

Vision loss may be classified according to the anatomical site of the problem. Anatomical disorders include impairment of the refractive structures of the eye, muscle anomalies in the visual system and problems of the receptive structures of the eye.

Refractive problems

Are the most common type of vision loss and occur when the refractive structures of the eye (cornea or lens) fail to focus light rays properly on the retina. The four types of refractive problems are hyperopia, or farsightedness; myopia, or nearsightedness; astigmatism, or blurred vision; and cataracts.

Hyperopia

Occurs when the eyeball is excessively short from front to back (has a flat corneal structure), forcing light rays to focus behind the retina. The person with hyperopia can clearly visualize objects at a distance but cannot see them at close range.

Myopia

Occurs when the eyeball is excessively long (has increased curvature of the corneal surface), forcing light rays to focus in front of the retina. The person with myopia can view objects at close range clearly but cannot see them from a distance (e.g., 100 feet). This individual requires eyeglasses to assist in focusing on distant objects.

Astigmatism

Occurs when the curvature or surface of the cornea is uneven, preventing light rays from converging at one point. The rays of light are refracted in different directions, and the visual images are unclear and distorted. Astigmatism may occur independently of or in conjunction with myopia or hyperopia.

Cataracts

Occur when the lens becomes opaque, resulting in severely distorted vision or total blindness. Surgical treatment for cataracts (such as lens implants) has advanced rapidly in recent years, returning to the individual most of the vision that was lost.

VISION LOSS/BLINDNESS
HELPFUL HINTS

Volunteers should be chosen for their ability to work with blind people and their willingness to learn. They need a genuine care and compassion for others that is free of pity or false feelings about blindness. Their primary role is to "supply eyes" for the person who is blind. They must be able to do this without dominating or fostering dependency or becoming involved with the inner problems of the blind person. They should encourage independence without trying to supply intelligence or make decisions for the blind person.

People with vision impairments have a variety of needs as a result of the loss of sight. It is important for the volunteer to respond to the actual expressed needs of the person and not to their own need to be helpful. While the relationship may be mutually beneficial, volunteering cannot be a way of solving one's own problems at the expense of another.

Some of the most frequent needs of people with vision impairments are assistance with reading, guide service and transportation. In each of these situations, the function of the volunteer is to supply eyes.

The volunteer can help with reading mail and answering letters. Other materials will need to be read such as the parish bulletin or the Pittsburgh Catholic. Many books are already available in braille, large print or cassette tapes. It is not necessary to duplicate services that are provided by various public organizations (see agency/organization list at the back of this book).

Volunteers who are providing transportation and guide service need to be familiar with the sighted guide technique which is described in another section of this book. Transportation to parish activities will be the main area of service. There are agencies that offer limited transportation service to other events.

Where blindness is accompanied by some other disability, there may be additional needs related to daily living.

Volunteer work should be done for a set and limited time each week. The volunteer needs to designate limits both in time and in the activities that he or she does. Otherwise it is possible for the volunteer to begin with much enthusiasm the activity that is required only to stop because the job has become too much.

It is not the role of the individual volunteer to provide financial assistance or other gifts. However, there may be times that the parish or Saint Vincent de Paul Society may be called on to do this.

- Treat people with vision impairments naturally as you would any other persons. Feel free to use words such as see and look. They understand them and probably also use them.

- Address people who are blind directly, not through a third party. Most have normal intelligence and are able to speak for themselves. Face them and look at them. They may have some residual vision.

- Use names so the person knows to whom you are speaking. Identify yourself by name so the person who is blind doesn't have to guess who you are.

- Speak in normal tone of voice. They have vision problems, not necessarily a hearing problem.

- Offer assistance, but let the person with vision impairment describe what kind of help is needed. Do not insist on helping when help is not desired.

- When guiding a person who is blind, ask if he or she would like a description of what you're seeing. Orient the person to new surroundings. Let the person know when you enter or leave a room.

- Be patient. People with vision impairments are quite capable of doing many things. Often they just need more time.
- Plan activities with the person who is vision impaired, not for him/her.

- Don't fuss over his/her accomplishments as "remarkable' or "wonderful." Vision impairment implies neither abnormality nor special gifts.

- Provide opportunities to hear, touch, smell, taste. They make an experience more meaningful.

- Speak with expression. It helps to make up for the lack of visual clues. People who are blind often miss information from the faces of speakers and their body language. Their own facial expressions may not accurately indicate what they are feeling or thinking.

- Never pet a guide dog in harness. Even when a dog is out of harness, ask permission before touching it.

- When you are introduced to a person who is blind, don't assume that you are meeting someone odd or different. He/she is the same as any other stranger. We all have disabilities to a greater or lesser degree.

- If the person's only disability is blindness, he/she is perfectly capable of walking on his/her own two feet. Let him/her take your arm, the movements of your body will guide him/her. He/she will walk along with you so naturally that most people who pass by probably won't realize that they are blind.

- Most persons who are blind have learned to live with their disability. Openly expressed pity is a

sign of bad manners. Of course, you may meet a martyr type occasionally; you meet them in all walks of life.

- Half open doors can be very dangerous. A person who is blind could injure themselves seriously by bumping into one. Keep all doors which may be used by persons who are blind either fully closed or open flat against a wall.

- When you enter a room which is occupied by a person who is blind, or he/she comes into a room that you are in, speak to him/her. If they do not recognize your voice, tell him/her who you are. You would do the same for a sighted person, wouldn't you?

- Always shake hands with a person who is blind when meeting or leaving them. Remember, a cordial handshake and a word or two are the same as a friendly smile that they can't see.

- You needn't be too obvious, but try to see that a friend who is blind meets the people around him/her at a party or in a group. If you can, identify each person by a word or phrase and don't fail to mention each name.

- A person who is blind can make up their own mind about what they want to do—where they want to go—what they like to eat. These are things he/she can decide for themselves. Give him/her any help they ask for, but don't try to assume responsibility which is rightfully theirs.

- Take it in your stride when a person who is blind does the ordinary thing in a routine manner. Don't gasp in audible wonder when he/she consults their watch (there are Braille watches), dial a phone or sign his/her name. He/she learned to do these things by study and practice, not by a miracle.

- Just because a person loses heir sight, it doesn't mean that he/she loses interest in life. He/she cold still know what is going on in the world, and they probably are still keenly interested in many of the things they used to do.

- Never push a person who is blind ahead of you in a strange place. In fact, don't do it whether it is strange or not. Let him/her take your right arm above the elbow. This will give you full control of your hands and it puts the person who is blind one step behind you. He/she will sense what you are doing and follow without hesitation.

- When a person who is blind is about to sit down, tell them where the seat is, or put his/her hand on the arm or back of the chair. He/she can sit down without your help.

- Never leave a person who is blind so quietly that they don't know you are gone. He/she might find him/her self talking foolishly to the empty air.

- When in a group, do not motion or whisper to the people who are sighted that "so and so" is blind. It is possible that the person who is blind will sense that something is going on and feel very uncomfortable.

- It is superstitious to believe that God has given a person who is blind some "extra super" sense to compensate for their lack of sight. In rehabilitation programs, the person who is blind has taken sensory training classes which provide them with procedures designed to maximize the use of all the senses. As with a sighted person, much use and practice of a particular skill leads to proficiency and perhaps excellence.

- It is very important to do away with the "living in darkness" idea of blindness. Most persons who are blind do not "live in darkness." Most have some light perception and some have form perception.

- Remember that each person who is blind is an individual—with individual characteristics. He/she has their own likes and dislikes—their own capabilities and limitations. Treat him/her as though they are individuals. It is a fallacy to believe that all persons who are blind are either geniuses or have no intelligence at all.

- Too many persons seem to believe that they must minimize their disability, otherwise they would not be showing the submission that God demands. Some give this notion to people who are blind: "Treat it as if it were not so bad as it is. Call it a minor burden. Don't think of it as severe or it will show that you are resentful of God's will." This strange belief, that the God of truth would ask us to deny the truth, is hard to understand. When we suffer pain, God does not expect that conformity to His will should make us say or think that it really isn't pain—"Kind of itchy, sort of a discomfort." So when a person is blind, they are not expected to minimize it, anymore than they are to exaggerate it. Rather, they are to see it as it is, in its full meaning. Only then can they give meaning to the prayer: "Father, not my will, but Yours be done." Christ in His Passion made no attempt to minimize his terrible suffering. He prayed to be free from it: "My Father, if it is possible, let this chalice pass from me." This is a prayer that the person who is blind has every right and every reason to say as they seek to free themselves from the disability of blindness - by restoration of sight and by every other means available, and as they try to make it less of a disability than it might be. Then Christ prayed as the person with a disability may also do: "But yet, not my will, but Yours be done."

SIGHTED GUIDE PROCEDURE

The sighted guide is a person who works as part of a team to enable a person who is blind to travel safely and efficiently in different environments and under varying conditions. He must react in time to any obstacles in the blind person's path such as curb, stairs, or to any dangerous situation he may encounter. In addition, he provides information about the environment through verbal explanations or specific body movements.

TO INITIATE CONTACT

1. Always ask the person if he/she would like to take your arm. **Never push or grab from behind.**

2. Place the back of your hand on the arm or hand of the person who is blind so they know where you are. If the person who is blind is untrained in the proper sighted guide technique, it is helpful to physically place his/her hand on your arm just above the elbow.

THE GRIP AND POSITION

1. The grip should be taken just above the elbow with thumb on the outside and fingers on the inside of the arm. Either arm can be used (left hand grips right arm or right hand grips left arm).

2. The grip should be firm but not tight, so as to be uncomfortable.

3. The forearm of the person who is blind is horizontal to the floor.

4. The guide is one-half step in front of the traveler who is blind.

5. The outside shoulder of the guide is directly in front of the outside shoulder of the traveler.

MOVEMENT

1. Walk at a normal speed (one that is comfortable to both parties in terms of speed and length of stride).

2. The guide should avoid obstacles, allowing enough room for the combined width of the guide and follower.

NARROW PASSAGEWAYS

If the walking area is judged to be too narrow for the combined width of two people, the guide places his arm behind his back so that the follower can move in closer to the guide. Return to original position after passing through the narrow space.

DOORWAYS

1. Inform the person who is blind that you are approaching stairs, their approximate number, and direction (up/down).

2. Approach stairs squarely whenever possible.

3. Pause slightly. Assist person in locating handrail if necessary. Allow time for the person to find the first step.

NOTE: For an escalator: the guide steps on first and the person who is blind follows, remaining on the step behind the guide and holding firmly onto railing. The guide steps off first and the person who is blind follows, maintaining position one-half step behind.

SEATING

Put the follower in contact with the chair (hand on the back edge of the chair or knees/shins in contact with the front edge of the seat).

Do not leave a person who is blind standing in an open space. If you are leaving him/her; place him/her in contact with a wall, a piece of furniture, etc.

Reprinted from

AMERICANS WITH DISABILITIES ACT FACT SHEET

with Specific References to Religious Institutions Included

Distributed by the National Catholic Office for Persons with Disabilities
Executive Director: Mary Jane Owen
1/27/03

EMPLOYERS——

· — may not discriminate against an individual with a disability in hiring or promotion if the person is otherwise qualified for the job.

· —can ask about one's ability to perform a job, but cannot inquire if someone has a disability or subject a person to tests that tend to screen out people with disabilities.

· —will need to provide "reasonable accommodation" to individuals with disabilities. This includes steps such as job restructuring and modification of equipment.

· — do not need to provide accommodations that impose an "undue hardship" on business operations.

· —with 25 or more employees must comply, effective July 26, 1992

· — with 15—24 employees must comply effective July 26, 1994.

A religious corporation, association, educational institution, or society may give a preference in employment to individuals of the particular religion, and may require that applicants and employees conform to the religious tenets of the organization. However, a religious organization may not discriminate against individuals who satisfy the permitted religious criteria on an equal basis with qualified individuals without disabilities who similarly satisfy the religious criteria.*

TRANSPORTATION

· New public transit buses ordered after August 26, 1990, must be accessible to individuals with disabilities.

· Transit authorities must provide comparable para-transit or other special transportation services to individuals with disabilities who cannot use fixed route bus service, unless an undue burden would result.

· Existing rail systems must have one accessible car per train by July 26, 1995.

· New rail cars ordered after August 26, 1990, must be accessible.

· New bus and train stations must be accessible.

· Key stations in rapid, light and commuter rail systems must be made accessible by July 26, 1993, with extensions up to 20 years for commuter rail (30 years for rapid and light rail).

· All existing Amtrak stations must be accessible by July 26, 2010.

STATE AND LOCAL GOVERNMENTS

· State and local governments may not discriminate against qualified individuals with disabilities.

· All government facilities, services and communications must be consistent with the requirements of Section 504 of the Rehabilitation Act of 1973.

PUBLIC ACCOMMODATIONS

· Private entities such as restaurants, hotels and retail stores may not discriminate against individuals with disabilities, effective January 26, 1992.

· Auxiliary aids and services must be provided

to individuals with vision or hearing impairments or other individuals with disabilities, unless an undue burden would result.

· Physical barriers in existing facilities must be removed, if removal is readily achievable. If not, alternative methods of providing the services must be offered, if they are readily achievable.

· All new construction and alterations of facilities must be accessible.

The ADA's exemption of religious organizations and religious entities controlled by religious organizations is very broad, encompassing a wide variety of situations. Religious organizations and entities controlled by religious organizations have no obligations under the public accommodation requirements of ADA. Even when a religious organization carries out activities that would otherwise make it a public accommodation, the religious organization is exempt from ADA coverage. Thus, if a church itself operates a day care center, a nursing home, a private school, or a diocesan school system, the operations of the center, home, school, or schools would not be subject to the requirements of the ADA or this part. The religious entity would not lose its exemption merely because the services provided were open to the general public. The test is whether the church or other religious organization operates the public accommodation, not which individuals receive the public accommodation's services.

Religious entities that are controlled by religious organizations are also exempt from the ADA's requirements. Many religious organizations in the United States use lay boards and other secular or corporate mechanisms to operate schools and an array of social services. The use of a lay board or other mechanism does not itself remove the ADA's religious exemption.

Thus, a parochial school, having religious doctrine in its curriculum and sponsored by a religious order, could be exempt either as a religious organization or as an entity controlled by a religious organization, even if it has a lay board. The test remains a factual one—whether the church or other religious organization controls the operations of the school or of the service or whether the school or service is itself a religious organization.

Although a religious organization or a religious entity that is controlled by a religious organization has no obligations under the rule, a public accommodation that is not itself a religious organization, but that operates a place of public accommodation in leased space on the property of a religious entity, which is not a place of worship, is subject to the rule's requirements if it is not under control of a religious organization. When a church rents meeting space, which is not a place of worship, to a local community group or to a private, independent day care center, the ADA applies to the activities of the local community group and day care center if a lease exists and consideration is paid.**

TELECOMMUNICATIONS

· Companies offering telephone service to the general public must offer telephone relay services to individuals who use telecommunication devices for the deaf (TDDs) or similar devices, effective July 26, 1993.

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*United States Employment Opportunity Commission Final ADA Rule, July, 1991.

**United States Department of Justice Final ADA Rule, July, 1991.

For more information about the ADA contact:

U.S. Department of Justice, Civil Rights Division
Coordination and Review Section
P.O. Box 66118
Washington, DC 20035-6118
(202) 514-0301 Voice

TIPS FOR PASTORAL CARE

For Persons with Disabilities

PHYSICAL/MOBILITY

- Ask about preferred location for seating.
- Don't push or touch a person's wheelchair without their permission.
- Don't assume people with canes or crutches prefer to use a ramp over stairs.
- Don't grab people's arms who use canes/crutches. They need their arms to balance themselves.
- Speak to the person in the wheelchair and not the person that may be accompanying them.
- Try to be eye-level with the person in the wheelchair when talking to them.
- Always ask before offering help. Don't be offended if the person says no.
- Never pet anyone on the head.
- A person with respiratory or heart condition may have difficulty walking long distances. Offer place to rest before ushering to seat.

BLINDNESS/PARTIALLY SIGHTED

- Prearrange tour of church with audio description.
- Identify yourself and your role (I am the greeter/usher).
- Ask person "Would you like to take my arm?" Describe scene.
- Walk on the opposite side of a guide dog.
- Give verbal cues that are specific (e.g. Don't say "watch out," say "there is a trash can in front of you…")
- Guide an individual's hand to a banister or the back of a chair to help direct him to a stairway or seat.
- Inform the person who is blind and attends church regularly of any physical changes.
- Offer large-print or braille bulletins and large-print prayer books and hymnals.
- Establish before Mass if a person would prefer the Eucharistic Minister to come to them or they would prefer to have a sighted guide.

DEAF/HARD OF HEARING

- Does the individual prefer to use sign language, writing, gesturing, speaking or a combination of all to communicate?
- To get the attention of a person who is deaf/hard of hearing, you can tap them on their shoulder, wave your hand or flicker the lights.
- Do not shout to a person who is wearing a hearing aid. Your shouting will be more distorted. Move closer to the individual.
- Face person directly when speaking and do not obscure your mouth when communicating.
- When using a sign-language interpreter, look directly at the person who is deaf, and maintain eye contact. Talk directly to the person who is deaf.
- Background noises are a problem for people who are hard of hearing. You may need to turn off radios and air conditioners.
- Don't be afraid of interaction. There is nothing worse than being left out and ignored.
- Offer assistive listening devices if available.

SPEECH DISABILITIES

- Ask the person to repeat themselves if you can't understand.
- Wait for the person to finish then restate to be sure you understand.
- Suggest another way of facilitating communication.
- Don't nod to a person you can't understand.
- Don't interrupt or finish a person's sentence.

COGNITIVE DISABILITIES

- Greet person normally. Don't baby talk.
- Repeat information about yourself if necessary.
- Rephrase, rather than repeat, sentences that the person doesn't understand.
- Treat people equally.
- Even if a person doesn't read, offer reading material.

BEHAVIORAL/MENTAL HEALTH

- Create a space available that parishioners can go to de-escalate challenging behavior.
- Don't force conversation.
- Don't argue. Wait for rational moments.
- Ask what will make him/her most comfortable and respect his needs to the maximum extent possible.
- Ask how you can help, find out if there is a support person who can be sent for.

OTHER TIPS

- Gestures often convey acceptance. Sit next to a person with a disability.
- If a person has a seizure, you cannot do anything to stop it. Be sure the person's head is protected.
- As an usher or greeter, please respect the person's needs and requests whenever possible.
- Don't make decisions for people with disabilities about what they can or can't do.
- A person who may appear drunk, sick or have a medical emergency might have Cerebral Palsy or another disability.
- Get the facts before acting on your first impression. Ask a person with a disability to usher.
- Ask a person with a disability to take up the offertory gifts or serve in other roles of ministry.

These tips have been provided using resources from:

Easter Paralyzed Veterans Administration
National Office for Persons with Disabilities
National Pastoral Life Center
Diocese of Wichita
Diocese of Boston
Liberty Resources
The Department for Pastoral Care for Persons with Disabilities Archdiocese of Philadelphia

Parish Accessibility Survey

In 1978 the U.S. Catholic Bishops declared in their Pastoral Statement on People with Disabilities:
It is essential that all forms of the liturgy be completely accessible to people with disabilities.... To exclude members of the parish from these celebrations of the l i f e of the Church, even by passive omission, is to deny the reality of that community.

To assess how well our parish is following the Bishops' mandate to do all in our power to... reach out to welcome people with disabilities who seek to participate in the ecclesial community, please take a few moments to complete this survey of facilities and ministries.

This is a tool for you to use so that you can see how accessible your community is.

Auditory Access to Worship and Activities:
Does our parish use the following to make worship and activities accessible to people who are deaf or hard of hearing?

Yes	No	
		Assistive listening devices (Infrared, Audio Loop, FM System)
		Sign / Oral interpreters
		Written text of verbal presentation
		Captioned audiovisual material

Are the following devices available and in working condition?

Yes	No	
		A visual emergency alarm system in the Church and Parish Center
		A telephone device for the deaf in parish administration center and staff familiar with use

Mobility Access to Church Facilities:

Is the parking area convenient and easily used by people with mobility impairments?

Yes	No	
		Clearly marked reserved parking spaces
		Paved access pathway to buildings
		4-foot wide curb cut to sidewalk

Is at least one entryway to each facility accessible to people with mobility impairments (parishioners and guests who use wheelchairs, canes, crutches, walkers or are unsteady)?

Yes	No	
		Ramp
		Ramp has hand rails on both sides
		Ramp has non-slip surface
		Lift device
		Elevator
		Steps have continuous hand rails
		Doors open easily or automatically
		Doors are at least 32 inches wide
		Smooth transition between doorway and floor surface

Are these areas accessible to people with mobility impairment?

Yes	No	
		Sanctuary
		Confessional
		Choir area
		Parish Center/Social Hall
		Parish Administration Building
		Restrooms/water fountains
		Telephones

Are there one or two pews 32" apart for use by people who use crutches or walkers?

Yes No

Have several pews been shortened (preferably in various locations) enabling people in wheelchairs to sit with family/friends?

Yes No

Visual Access to Worship and Activities:

Which of the following does our parish use to make worship and activities accessible to people with visual impairment?

Yes	No	
		Large print material (worship aids, hymnals, bulletins, newsletters, signs)
		Braille material
		Audio cassette material
		Audio description

Are the following areas well lighted?

Yes	No	
		Parking area
		Approach and entryways to buildings, Body of Church
		Sanctuary
		Parish Center

Are the facilities accessible to persons with visual impairments?

Yes	No	
		Free of hazardous over-hangs and protruding objects
		Clearly marked abrupt changes in levels

Other Access Issues:
Has there been a survey or is there a place on the parish registration form to ascertain if any parishioners have allergies or chemical sensitivities to such things as the wheat host, paint, perfume, cleaning fluids, etc.?

Yes No

Have accommodations been made to enable such persons to participate in worship?

Yes No

MINISTRY ACCESS:

To your knowledge, people with disabilities serve in which of the following ministries:

People with Impairments of:	Mobility	Vision	Hearing	Mental Challenged	Other
Altar Servers					
Catechist					
Eucharist Ministers					
Greeters/Ushers					
Lectors					
Parish Council					
Parish Staff					
Youth Ministry					
Service Groups					
Special Ministries					

SAMPLE

(To be printed on parish stationery)

PARISH SURVEY FOR PERSONS WITH DISABILITIES

Name of person with a disability: _____

Street Address: _____ Apt. # _____

City _____ State _____ Zip _____

Phone: _____ Age _____ E-mail _____

Type of Disability: _____
(i.e. cognitive, sensory, physical, etc.)

How can our parish assist with your spiritual and/or religious needs?

_____

_____

_____

_____

What can we do to improve our parish facilities to meet your needs?

_____

_____

_____

_____

Please return to _____ at the above address. Thank you.

Sample

Letter to Accompany Survey

Name of Parish - (to be printed on parish letterhead)

Dear fellow parishioner,

Our parish is seeking to identify any parishioners who have disabilities. We are doing this so that we can assist persons with disabilities with their religious and spiritual needs.

If you, or a member of your family have a disability, will you please fill out the enclosed form and return it to the parish office by _____.

In His Hands Ministry is a ministry for families who have children with disabilities who are parishioners of Vicariate IV. This ministry will promote social and formational events and promote awarenss of disabilities to insure that all are welcome in our Parishes. We look forward to hearing from you.

If you have any questions, please don't hesitate to call me.

Sincerely,

(Pastor and/or Parish Advocate)