Community & Residential Services Authority

ANNUAL REPORT

FISCAL YEAR 2018

(July 1, 2017 - June 30, 2018)

Building Partnerships for Children and Families

The mission of the Community and Residential Services Authority is to actively advocate, plan and promote the development and coordination of a full array of prevention and intervention services to meet the unique needs of individuals with a behavior disorder or a severe emotional disturbance and their family.

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LETTER OF TRANSMITTAL

Governor Bruce Rauner
Members of the General Assembly
State Agency Directors and
State Superintendent of Education
Springfield, Illinois

Dear Governor Rauner, Members of the General Assembly, State Agency Directors and Superintendent of Education:

On behalf of the membership of the Community and Residential Services Authority, I transmit herewith the 32nd Annual Report. I am pleased to present this summary of activities for Fiscal Year 2018 in accordance with the requirements as set forth in Ch. 122, Sec. 14-15.01 of the Illinois School Code.

Respectfully submitted,

Seth Harkins, EdD
Chairperson

LEGISLATIVE MEMBERS

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Senate Committee on Elementary & Secondary Education
Carie Johnstone, Designee

Senator Chuck Weaver
Senate Committee on Elementary & Secondary Education
Matt George, Designee

Representative Fred Crespo
House Committee on Elementary & Secondary Education
Dr. Seth Harkins, Designee, Chairperson*

Representative Robert Prichard
House Committee on Elementary & Secondary Education
Dr. Kathleen Briseno, Designee**

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Illinois Department of Healthcare and Family Services

Ms. Juliana Harms*
Illinois Department of Children and Family Services

Mr. Randy Staton*
Illinois Department of Human Services
Division of Rehabilitation Services

Ms. Maureen Haugh-Stover**
Illinois Department of Human Services
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Mr. Mark Smith
Illinois Department of Juvenile Justice

Ms. Lisa Betz
Illinois Department of Human Services
Division of Mental Health

Ms. Brittany Rosenbloom
Illinois Attorney General's Office

Ms. Cindy Knight/Abbey Storey
Illinois State Board of Education

Ms. Julie Stremlau, Secretary*
Illinois Department of Human Services
Office of Family and Community Services

GOVERNOR'S APPOINTEES

Mr. Neal Takiff
Gubernatorial Appointee

Dr. Robert Bloom*
Gubernatorial Appointee

Mr. Gary Seelbach*
Gubernatorial Appointee

Dr. Andrew Beatty
Gubernatorial Appointee

Judge Stephen Sawyer
Gubernatorial Appointee

Mr. Merlin Lehman**
Gubernatorial Appointee

*** Executive Committee**
****Executive Committee Alternate**

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WHO WE ARE

The Community and Residential Services Authority (CRSA) was established by the Illinois General Assembly in 1985 because children, who exhibit multiple impairments/disabilities, including behavior disorders or severe emotional disturbances, historically present challenges to Illinois' state service system as agencies and schools try to address the diverse service needs of this population. Many of these children do not clearly fit the eligibility criteria or funding streams of state and local public agencies and therefore, go un-served or are underserved by the very systems established to help them.

The State of Illinois provides an extensive array of services to its children and adolescents, but like many other states, has encountered difficulty connecting various public and private services. Children and adolescents who are labeled severely emotionally or behaviorally disordered have multiple service needs. They frequently require a blend of educational, social, psychological and other support services that may not clearly fit the service eligibility criteria or funding patterns of public agencies. These circumstances may create confusion and occasional disputes between state and local human service agencies and schools and between agencies and parents. The CRSA assists all parties in obtaining the overall objective regarding the best interest of the child on our caseload. When that cannot happen in a collaborative agreement at the Regional Coordinator level, the CRSA board can review the case in a Dispute Resolution meeting.

The Community and Residential Services Authority (CRSA) has been able to identify the Illinois social service barriers for children with complex mental health challenges. In FY18, the CRSA facilitated cohesive complex service planning for 263 children with severe behavioral/emotional disabilities and or complex educational needs who faced barriers to accessing the Illinois public and private services designated to help them.

The CRSA has nineteen members: nine representatives of child-serving state agencies, six public and private sector gubernatorial appointees and four members of the General Assembly or their designees. The CRSA employs an Executive Director who operates with the assistance of three expert Regional Coordinators and two support professionals to fulfill the CRSA's statutory mandates. CRSA was given the following powers and duties:

- To conduct surveys to determine the extent of need, the degree to which documented need is currently being met and feasible alternatives for matching need with resources.
- To develop policy statements for interagency cooperation to cover all aspects of service delivery, including laws, regulations and procedures, and clear guidelines for determining responsibility at all times.
- To recommend policy statements and provide information regarding effective programs for delivery of services to all individuals with a behavior disorder or a severe emotional disturbance in public or private situations.
- To review the criteria for service eligibility, provision and availability established by the governmental agencies represented on this Authority, and to recommend changes, additions or deletions to such criteria.
- To develop and submit to the Governor, the General Assembly, the Directors of the agencies represented on the Authority and the State Board of Education a master plan for individuals with a behavior disorder or a severe emotional disturbance, including detailed plans of service ranging

from the least to the most restrictive options; and to assist local communities, upon request, in developing or strengthening collaborative interagency networks.

- To develop a process for making determinations in situations where there is a dispute relative to a plan of service for individuals or funding for a plan of service.
- To provide technical assistance to parents, service consumers, providers, and member agency personnel regarding statutory responsibilities of human service and educational agencies, and to provide such assistance as deemed necessary to appropriately access needed services.

OPERATIONS

The following is a description of the operational structure of CRSA when receiving a referral:

Intake

- Intake involves receiving, establishing eligibility for CRSA services, documenting and processing the issues, complaints or questions from an individual, or from an individual on behalf of an organization.
- Personnel implementing Intake: CRSA has a designed Intake Coordinator.

Implementation

- Implementation involves general information gathering, making referrals, specialized resource acquisition, coordination with public and private organizations regarding a common plan of care.
- Personnel: CRSA employs three Regional Coordinators statewide to implement these objectives.

Dispute Resolution

- Dispute resolution occurs when there is a disagreement between a parent/guardian and an agency represented on the Authority regarding a plan of services; or a disagreement between two or more member agencies regarding implementation of a plan of services. The Authority has a mandate "to develop a process for making determinations in situations where there is a dispute relative to a plan of service for individuals or funding for a plan of service". While each state agency has its own internal review processes, Illinois needed a statewide process to resolve multiple-agency disputes so it was built into the CRSA legislation.
- Personnel: The director and board chair determines the dispute resolution team, which consists of relevant board members.
- Process: staff and members collaborate to explore voluntary solutions to complex multi-agency, multi-systems issues regarding a plan of care. During FY18, all potential dispute resolution cases were resolved through informal consults with relevant agency board members.

FY 2018 OBSERVATIONS FROM CRSA STAFF

Intensive and integrated community based treatment for youth with mental illnesses are not available to all youth throughout the state:

During FY18, CRSA Regional Coordinators noted a caseload trend that public funding for psychiatric residential placements was less difficult for parents to obtain for their children with severe mental illness this year. This directly correlated with a change in the full administration of the Individual Care Grant (ICG) from Division of Mental Health to Healthcare and Family Services (HFS) which funds community and residential treatment. HFS streamlined the ICG application process. This helped several CRSA involved families obtain access to the ICG.
The CRSA Regional Coordinators observed this fiscal year that many local mental health facilities were progressively less available to provide intensive outpatient therapy and case management services for youth with severe emotional disabilities. Overall, intensive outpatient therapy and case management services (delivered more than once a week) were seldom available unless that youth lived in an area that HFS provided care coordination entities such as "Choices" to support integrative intensive plans of care. CRSA involved youth receiving Choices case coordination seemed to greatly benefit from this "wraparound" approach to case management. Case coordination done in the Choices regions at times offered enough community based services to support, postpone and or avert a youth's impending need for residential care. CRSA involved youth appeared also to benefit educationally from the ongoing supports that the Choices Case Coordinators provided to them at educational planning meetings.

Access to Psychiatric Residential Treatment:

This fiscal year CRSA Coordinators noted that residential treatment facilities had longer waiting lists than usual. The most difficult to place youth were youth who presented with complex treatment needs such as severe mental health issues, behavioral problems, coexisting developmental disabilities, juvenile justice histories and or other health impairments.

Transitional living arrangements were scarce:

Youth in transition from psychiatric residential treatment to home, had difficulty obtaining the stabilizing publically funded home-based transitional support services prescribed at discharge. Of much concern to CRSA staff, were that some of these youths had little to no successful trials of less restrictive levels of care before they were discharged. Once back in their community, some young adults with the primary diagnosis of a mental health disorders requiring a step-down transitional living arrangement, often did not qualify for an adult psychiatric residential group home. Typically, they were told that they were not chronically mentally ill enough, were too immature, non-compliant, or too aggressive to fit in the milieu for an adult group. Community residences for these youth at times depended upon the availability of public housing. Coordinating services for a youth in public housing who is leaving the child serving mental health system and transitioning into the adult mental health system has been awkward for our clients. There was no clear pathway for this transition although CRSA's staffs worked diligently with agencies whose missions are to help these youths. Agencies like the Illinois Communities for Integrative Living, CIL. CIL agencies have helped individuals statewide connect to vital community services however, they cannot provide housing, which continues to be a much needed resource.

Children on the Autism Spectrum were not receiving access to recommended treatment:

Children with autism were reported by CRSA Regional Coordinators to be notably underserved in the area of early interventions and or intensive in home behavioral supports. It was quite difficult to find a funder, private or public that would pay for evidenced based treatments for youth with Autism. This is concerning to CRSA regional coordinators due to best practice statistics indicating that early intervention with children that have Autism produces a better therapeutic benefit than interventions later in childhood. *"Early interventions not only give children the best start possible, but also the best chance of developing to their full potential. The sooner a child gets help, the greater the chance for learning and progress. In fact, recent guidelines suggest starting an integrated developmental and behavioral intervention as soon as ASD is diagnosed or seriously suspected."*[1] CRSA has not typically gathered treatment access data specifically on this population however it will be added to our statistical tracking to quantify this issue due to a steady increase of referrals of children who are dually diagnosed with an emotional disability and autism.

During FY18, the CRSA continued to focus attention and discussion on the changing community-based service systems and emergent populations of youth and families who did not completely meet or understand how to access state funded local mental health and educational services. CRSA staff successfully linked families to resources as standard operations, however families voiced additional confusion regarding the statewide changes in the Medicaid as the conversion to managed care got underway. The CRSA board asked to see a statewide service map that would identify how to access public services to decrease confusion. A complete service map did not exist and was not possible to create at that time.

- **Family Support Program implementation:** The Authority continued to serve clients who were impacted by the HFS conversion of the Individual Care Grant (ICG) Program aka Rule 135 to the Family Support Program (FSP) aka Rule 139. The ICG had historically been a vital staple for children with mental illness and their families to obtain "non-means based" public funding for youth needing mental health treatment. At the end of FY17, the legislature moved the ICG program and its funding from the Department of Human Services (DHS) to the Department of Healthcare and Family Services (HFS). HFS reduced critical administrative barriers to the ICG application process. One barrier that still remained for most of FY18 was the requirement for the applicants to obtain a Psychological evaluation. This was a barrier because there were very few psychologists in Illinois who were approved to provide services to the Medicaid population. Children with private insurance also had limited access to psychologists due to rules set by their plan providers. In the Spring of 2018, HFS introduced the Family Support Program application online. HFS did not remove the requirement for a psychological evaluation for youth who were being evaluated for residential treatment however they eliminated the requirement that a psychological be obtained as a requirement to apply for the FSP. This made a big difference to the CRSA involved families seeking intensive home based services and or residential care.

[1] https://www.nichd.nih.gov/health/topics/autism/conditioninfo/treatments/early-intervention

- **Implementation of the N.B. Class action lawsuit:** N.B is a class action lawsuit pertaining to Illinois' failure to provide Early Periodic Screening Diagnosis and Treatment (EPSDT). On January 16, 2018, a Class Action Settlement (Consent Decree) was entered in Federal Court in Chicago, Illinois. N.B. v. Norwood, Case No. 11-6866. It concluded that all persons under the age of 21 and are Medicaid eligible in the State of Illinois, who have been diagnosed with a mental health or behavioral disorder or developmental disability and who have received a recommendation for intensive home or community base services to address their disorders, are entitled under the court settlement to receive these home or community based services. In June 2018, John O'Brien was court appointed as the expert to oversee the implementation of the NB consent decree. CRSA will continue to monitor how the Consent Decree appears to align with the HFS Integrated Healthcare, Medical Health Homes, Behavioral Health Clinics, and Community Mental Health Center services. This, when implemented, is anticipated to significantly impact the technical assistance facilitation done by CRSA Regional Coordinators.

- **The 1115 Waiver approval:** In May 2018, the Illinois Department of Healthcare and Family Services received approval of its 1115 waiver. This waiver includes pilots designed to better serve Medicaid beneficiaries in need of behavioral health services. It is anticipated by CRSA staffs that this waiver may support improved access for youth with high acuity mental health needs to get access to more intensive stabilization and counseling services. The waiver authorizes the state to receive federal financial participation (FFP) for a continuum of services to treat addictions to opioids and other substances, as well as, other behavioral health conditions. The programs and related innovations are known as the Better Care Illinois Behavioral Health Initiative.

  CRSA staff were excited to learn that HFS is preparing to implement an Intensive In-Home services pilot as a key component of the Better Care Illinois Behavioral Health Initiative. This particular pilot is designed to offer in-home, team-based, clinical and supportive services to children ages 6-21 with complex behavioral health needs."[2] We anticipate these intensive clinical services will assist in the stabilization of youth who previously may have been referrals to CRSA for residential care funding resources. These intensive services will impact the CRSA population of children with mental illness involved in the FSP program. CRSA staff will stay informed regarding the implementation of this pilot as we monitor the impact on CRSA referred clients.

- **Specialized Family Support Services as related to custody relinquishment of youth in Psychiatric crisis:**
  A lockout is a situation in which a youth's parent refuses to allow him/her to return home upon discharge from a psychiatric hospital or residential treatment facility, or a situation in which a parent refuses to pick up the child from a facility, and has refused or failed to make provisions for an alternative living arrangement[3]. Custody relinquishment comes with great stress as families feel forced to consider giving up guardianship of their child with mental illness in order for that child to get state-funded psychiatric treatment. In addition, custodial relinquishment can occur when parents have safety concerns when their psychiatrically unstable child threatens to harm themselves, siblings, family members, classmates and or community members.

[2] https://www.illinois.gov/HFS/Pages/default.aspx
[3] http://www.whittedtakifflaw.com/

In FY16, the CRSA received 44 referrals involving active psychiatric lockouts and the resultant custody relinquishment risk. In FY17 27, in FY18, the number dropped significantly to 14. CRSA involved families benefitted from the implementation of PA 0808 and the HFS initiation of the Family Support Program, Specialized Family Support services SFSP. Even though SFSP implementation seriously lacked available temporary transitional beds for the population of youth who could not physically return home directly from the hospital, tri-agency case management (DCFS, HFS and DMH) was responsive. CRSA was told that within this next fiscal year, the implementation of NB vs Norwood protocols and the SFSP program will be designed and or refined. If best practice protocols are established and followed, less custody relinquishments for CRSA involved youth state-wide are expected. Senate Public Act 100-0978 is expected to pass in FY19 which adds additional protocols and clarity to PA 0808[4].

Youth with a primary diagnosis of Intellectual Developmental Disability (IDD)

CRSA staff observed that in the sample of the population we served that youth with intellectual developmental disabilities (IDD) were often underserved in the area of community-based behavioral therapy. For instance, Healthcare and Family Services (HFS) funded Screening Assessment and Support Services (SASS) behavioral health providers were obligated to screen and assess all Medicaid eligible youth who presented a psychiatric crisis prior to an admission to a psychiatric hospital. This included Medicaid eligible youth with IDD. SASS was also required to monitor hospitalizations, assist with discharge planning and then to provide stabilization services afterwards. In most regions, from CRSA staff perspective, youth with IDD received little to no inpatient and or post-hospitalization follow up from SASS. Mental Health centers told us that they were not typically trained to work intensively with youth who have a limited capacity for insight aka youth who have intelligence quotients that fall below 70. After a Medicaid mandated SASS crisis screening, SASS providers typically referred youth with IDD to their local developmental disabilities providers for post crisis follow up. Intensive in home supports and treatment from the local developmental disabilities providers are not as available to youth as SASS services are to youth with mental health disorders.

DDD in Illinois operates HFS Home and Community Based Services Waiver Programs called the Home and Community Based Services Support Waiver for Children and Young Adults with Developmental Disabilities. This waiver is difficult to obtain and is not intended to be an immediate post-hospitalization stabilization service. The waiver is for children and young adults with developmental disabilities ages three through 21 who live at home with their families and are at risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities. Support services teams (SST) through DDD were and still are typically available to a narrow amount of children who have already been chosen to receive the Children's In-Home Support waiver. SST services were not automatically allocated to Medicaid eligible youth with IDD post psychiatric hospitalization. In short, parents report to CRSA staffs that their youths with IDD who were at risk of entering or have entered psychiatric hospitals, receive little to no post hospitalization follow up supports unless they have met the selective and intensive criteria for SST services or have access to additional DMHDD home based supports.

[4] http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=098-0808

FISCAL YEAR 2018 ACTIVITIES

The CRSA board held five full board meetings during FY18 that focused on promoting and implementing the concepts advanced in CRSA Strategic Plans in addition to providing technical assistance and carrying out dispute resolution responsibilities.

During FY18, CRSA staff directly participated in 159 client progress meetings, school special education conferences and multiple-agency planning teams. The Executive Director and three, full time CRSA Regional Coordinators participated in 102 activities with agencies, organizations and groups and maintaining liaison relationships with statewide planning groups. Such groups include the Attorney General's Special Education Committee, the Children's Behavioral Health Association, the Mental Health Summit, Community Behavioral Health Association, St Clair County Youth Council, and the DCFS Immersion Site Stakeholder meetings just to name a few.

FISCAL YEAR 2018 CASELOAD TRENDS

During FY18, CRSA cases continued to be complex, requiring sustained technical assistance, often over a period of months in order to access needed services.

The CRSA has a case monitoring system that tracks key client demographics, reasons for referrals and diagnostic information. From these data, fiscal year trends were obtained.

It appeared increasingly common for children and young adults referred to CRSA to have between two to five diagnosed disabilities and to exhibit four or more serious behavior problems at the time of referral. These individuals often had service needs for which two or more member agencies had overlapping service and funding responsibilities.

During FY18, CRSA staff responded to 263 calls for assistance. CRSA records all diagnoses reported by the referral source. Any one child could have more than one condition or diagnosis. The following is a breakdown of the CRSA referred youth's medical coverage, diagnosis, functioning level, and difficulty of care factors as reported to CRSA staff:

Medical coverage

- Medicaid: 163
- Private Insurance: 84
- Not Disclosed: 16

Diagnosis: (not mutually exclusive)

- ADHD/ADD: 125
- Autism: 100
- Anxiety Disorder: 82
- Depression: 54
- Disruptive Mood Dysregulation Disorder: 35
- Bipolar Disorder: 35
- Intellectual Disability and Mental Illness: 33
- Eating Disorder: 33
- Developmental Disability "Other": 28
- Post-Traumatic Stress Disorder: 21
- Mental Health "Other": 17
- Obsessive Compulsive Disorder: 15
- Psychotic Disorder: 10
- Oppositional Defiant Disorder: 48
- Reactive Attachment Disorder: 25
- Intermittent Explosive Disorder: 15
- Conduct Disorder: 5
- Personality Disorder: 4
- Other: 10
- Traumatic or Acquired Brain Injury: 9
- Fetal Alcohol Spectrum Disorder: 8

Functioning Levels

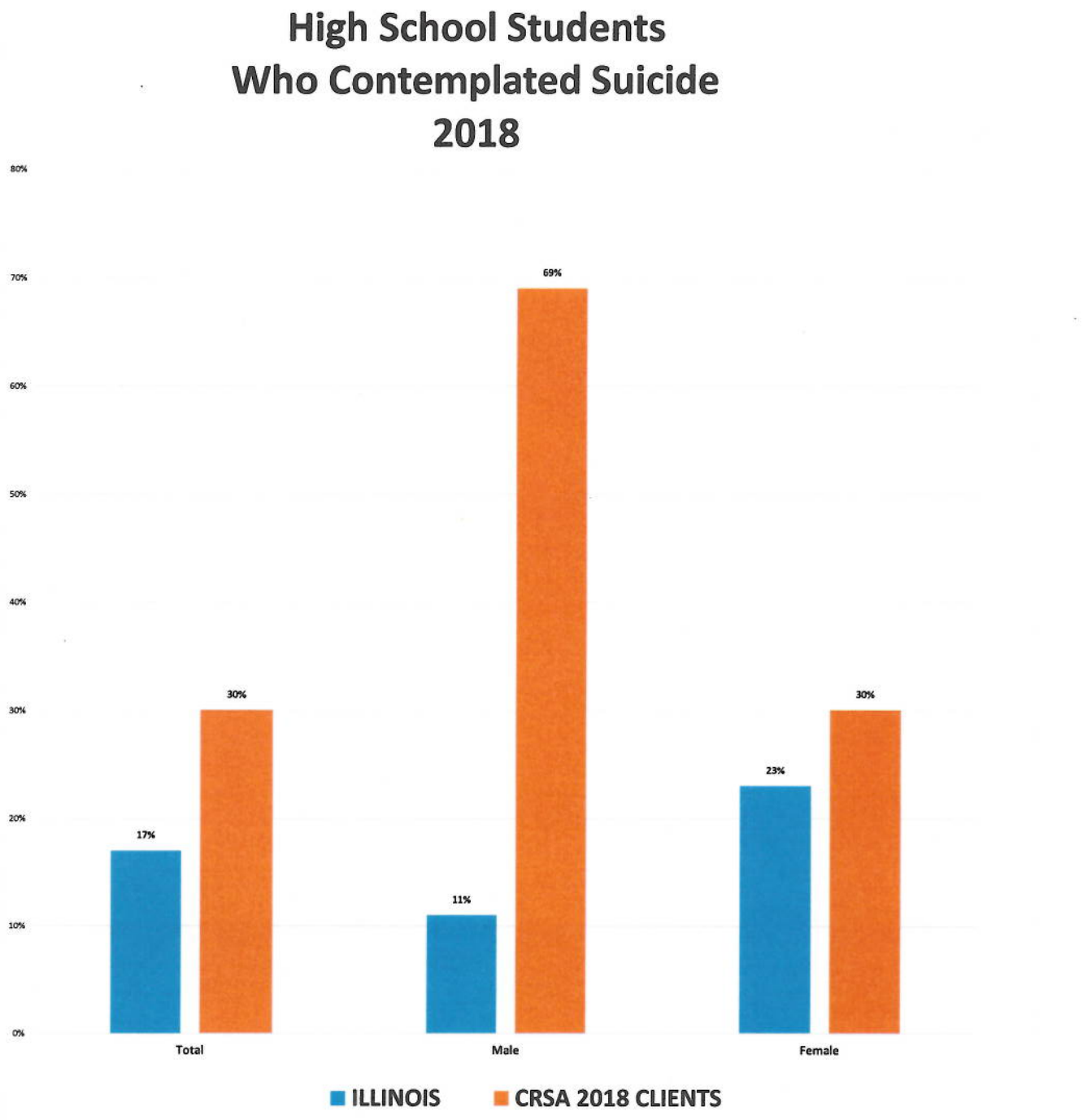
- Youth with IQ's above 70: 194
- Youth with IQ's below 70: 69

Difficulty of Care Factors:

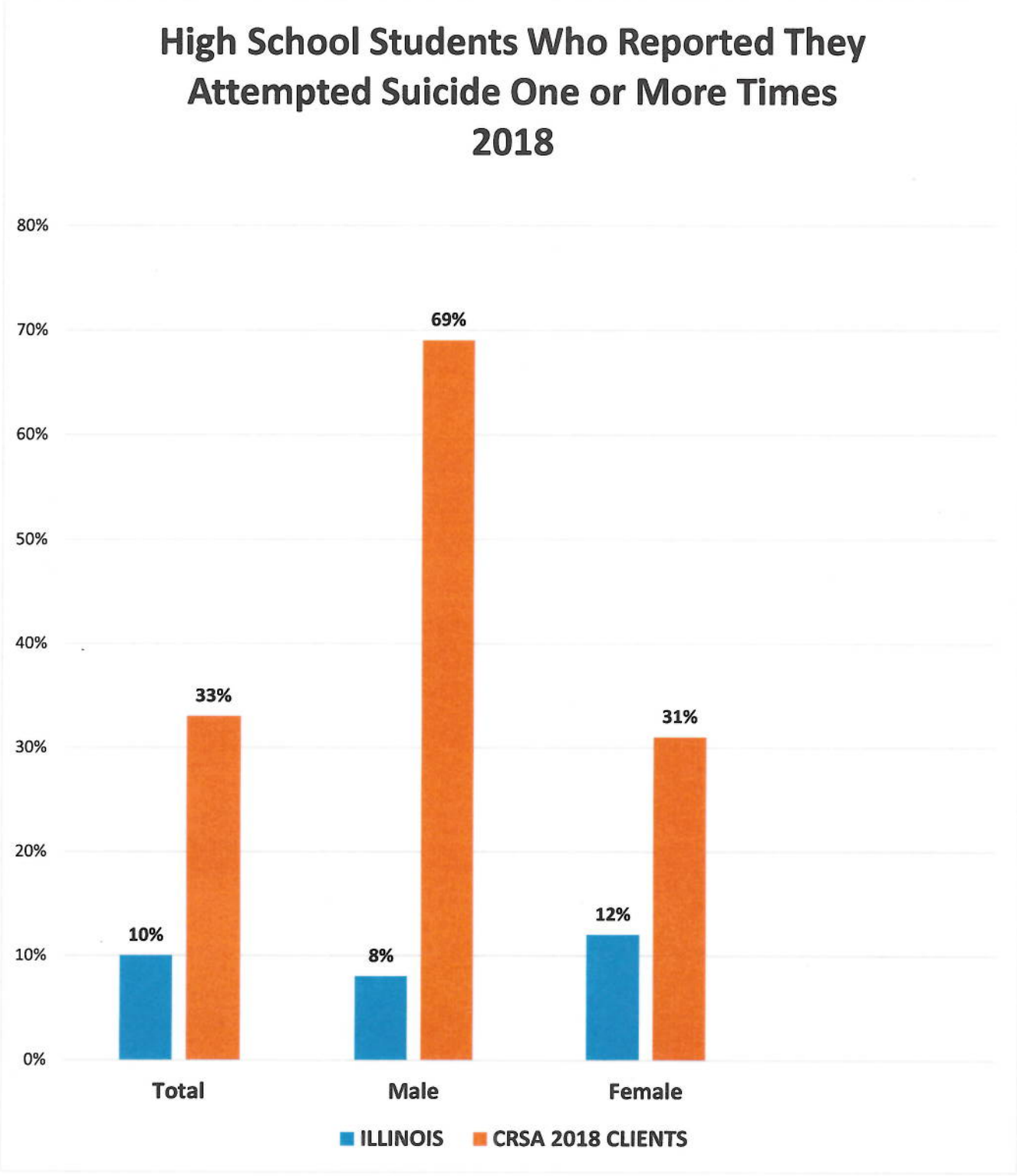
- Physical Aggression: 151
- Self-harming: 87
- Suicidal Ideation: 79
- Homicidal Ideation: 61
- Runaway Risks: 67
- Sexually Inappropriate Behaviors: 5 4
- Medically Resistant: 34
- Fire Setting: 31
- Sexually Aggressive: 24
- Substance Abuse: 14
- Lockout Risk: 14
- Physical Disability: 3

Regarding suicide risks, the following is a comparison of CRSA referrals with a survey conducted by Illinois Adolescent Mental Health Facts, one can easily see the referrals to CRSA were above the Illinois norms for Suicidal thoughts, attempts, and related injuries among high school students (grades 9-12).

The chart below shows the percent of high school students who reported they seriously considered attempting suicide. This was during the 12 months before the survey.



The chart below shows the percent of high school students who reported they attempted suicide one or more times. This was during the 12 months before the survey.



CONSUMER SATISFACTION SURVEY'S

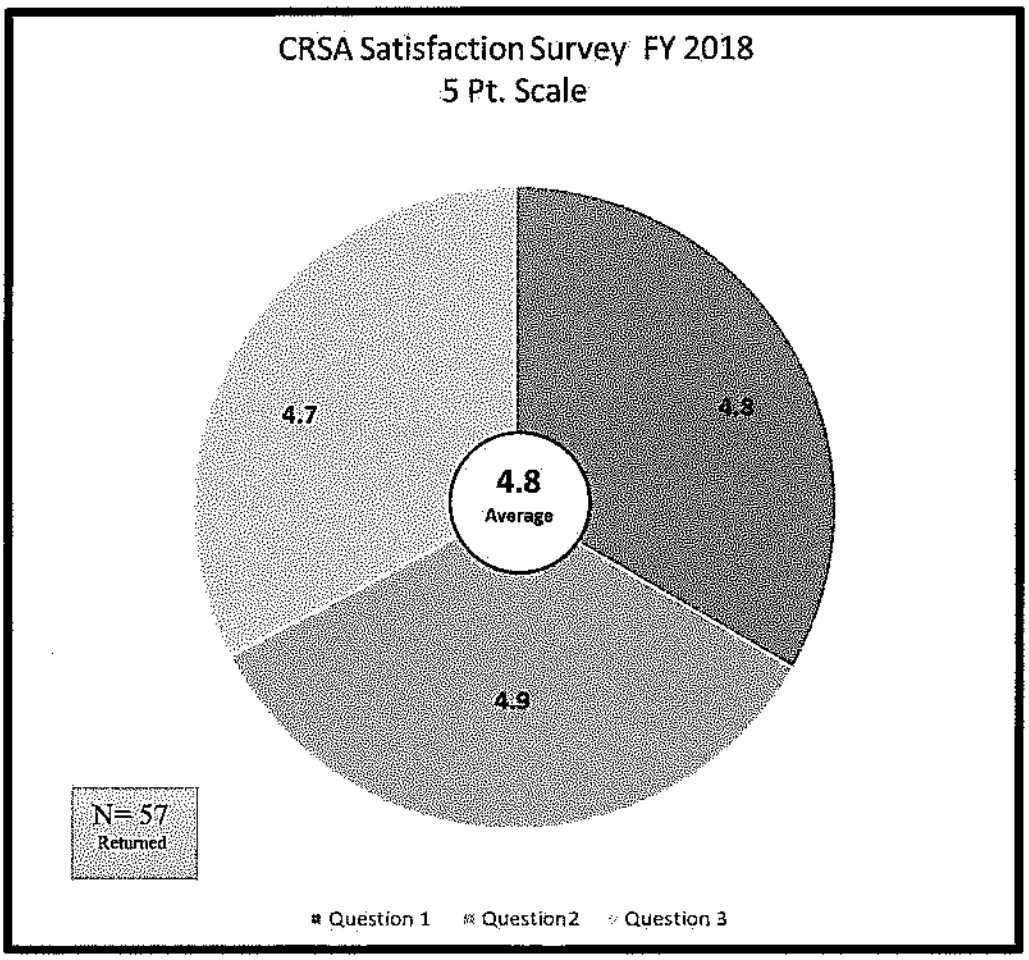
CRSA is a unique agency, which will never have the same exact issue for any given case. Staff to the CRSA are consultants, troubleshooters and sometimes a "systems alarm bell". Overall, CRSA staff mostly function as a "systems- guide" and collaborative partner for parents, agencies and communities. CRSA staff understand protocols for accessing established state services and resources for youth with behavioral health care needs.

The consumer satisfaction survey is a questionnaire consisting of three simple questions scored on a one to five scale -- five being the highest rating and one being the lowest rating. The survey is distributed to every referent approximately 30 days after the date of referral with a self-addressed stamped envelope to maximize returns. Responses indicate the levels of satisfaction with:

Question 1: Was the Community and Residential Services Authority prompt in acting on your request for assistance?

Question 2: Were your ideas treated with respect?

Question 3: Did the CRSA give you or the child needed help?



FISCAL YEAR 2018 EXPENDITURES

COMMUNITY AND RESIDENTIAL SERVICES AUTHORITY
FY 2018
APPROPRIATION/EXPENDITURE SUMMARY

FY 2018 APPROPRIATION	**$579,000.00**
FY 2018 EXPENDITURE	**$525,825.78**
LAPSED FUNDS	**$53,174.22**

TYPE OF EXPENDITURE	ALLOTMENT	EXPENDITURE	BALANCE
PERSONNEL SERVICES			
CRSA Employee Salaries	$407,500.00	$387,118.00	$20,382.00
Retirement Reserve	$25,000.00	$20,022.98	$4,977.02
Benefits Package	$32,000.00	$29,936.09	$2,063.91
Contractual Employee	$0.00	$4,809.75	($4,809.75)
Staff Travel	$30,000.00	$27,847.40	$2,152.60
CONTRACTUAL SERVICES			
Members Travel	$10,000.00	$3,725.91	$6,274.09
Space Allocation	$45,000.00	$21,715.20	$23,284.80
Administrative Services	$10,000.00	$6,426.76	$3,573.24
Staff/Board Training	$4,000.00	$1,580.00	$2,420.00
IT Support	$5,000.00	$0.00	$5,000.00
Meeting Expense	$500.00	$0.00	$500.00
COMMODITIES			
Office Expenses	$10,000.00	$22,643.69	($12,643.69)

* *These are funds which were allocated to meet anticipated needs but which did not need to be expended during this Fiscal Year.*

FUTURE DIRECTIONS

This year ushered in new board members and said good-bye to some long standing members of staff and the board. The CRSA Executive Committee hired a new Director, a former CRSA Regional Coordinator who started mid fiscal year 2018. These changes offered the CRSA board new opportunities to reevaluate the direction the CRSA will take in FY19.

The CRSA board is a diverse mix of experienced, well accomplished, legislative, community, parent and state-agency leaders. CRSA has a wide universe of knowledge to utilize as we address the objectives set forth in the CRSA legislation. The board will be using their collective expertise to redesign the strategic plan which will support initiatives that significantly impact youth services in Illinois.

- CRSA will monitor and objectively comment on legislative changes that significantly impact the CRSA service population.
- CRSA will embark on an aggressive campaign to reach out to neighborhoods and communities and organizations that serve like populations.
- CRSA will track new data sets regarding our service population in order to better asses the challenges that face children and families who struggle with mental illness and co-existing disorders such as Autism and Developmental Disabilities.
- CRSA will compare the incidence of school safety and mental health issues for referred youth.
- CRSA will track the impact of video games and video gaming addictions on physical aggression in youth who are referred for assistance
- CRSA staff will serve on statewide non-partisan coalitions and committees to assist communities and agencies in developing services that improve the lives of children with mental health conditions in Illinois.
- CRSA will work with CMS to improve data tracking from Excel to an interactive data base. Currently CRSA uses an outdated data gathering and monitoring system which limits our ability to adequately track trends in real-time for the board, legislators and the general public.
- CRSA will watch and proactively assist parents in understanding the implementation of the HFS mental health programs geared toward our service population.

DEFINITION PAGE

- **Advocates:** State, federal and private advocacy agencies/groups/individuals, lawyers
- **CIL:** Community for Integrative Living
- **CRSA:** Community and Residential Services Authority
- **DCFS:** Illinois Department of Children and Family Services
- **DHS:** Illinois Department of Human Services
- **DJJ:** Illinois Department of Juvenile Justice
- **FFP:** Federal Financial Participation
- **FSP:** Family Support Program
- **HFS:** Illinois Department of Healthcare and Family Services
- **ICG:** Individual Care Grant
- **IDD:** Intellectual Development Disorder
- **IEP:** Individual Education Plan
- **ISBE:** Illinois State Board of Education
- **LEAS:** Local Educational Agencies
- **NB:** NB vs. Norwood class action law suit
- **Parents:** Parent(s) or legal guardian
- **SASS:** Screening Assessment and Support Services
- **SFSP:** Specialized Family Support Program

- **Community Agencies:**
  - Local community direct service provider agency

- **State Agencies:**
  - Illinois State Board of Education;
  - Department of Children and Family Services;
  - Department of Juvenile Justice;
  - Department of Human Services:
    - Divisions of Mental Health,
    - Developmental Disabilities,
    - Rehabilitation Services,
    - Family & Community Services
    - Illinois Department of Healthcare and Family Services