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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

# INSTRUCTIONS

## FOR UPDATING THE

# IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515)281-3355 or (515)242-6873

### **Human Services Department[441]**

- Replace Chapters 51 and 52
- Replace Chapter 77
- Replace Chapter 81
- Replace Chapters 109 and 110
- Replace Chapter 117
- Replace Chapter 200

### **Dental Board[650]**

- Replace Analysis
- Replace Chapter 29
- Insert Chapter 52

### **Nursing Board[655]**

- Replace Analysis
- Replace Chapter 3

### **Revenue Department[701]**

- Replace Analysis
- Replace Chapters 67 to 69



CHAPTER 51  
ELIGIBILITY

[Prior to 7/1/83, Social Services[770] Ch 51]

[Prior to 2/11/87, Human Services[498]]

**441—51.1(249) Application for other benefits.** An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

This rule is intended to implement Iowa Code section 249.3.

**441—51.2(249) Supplementation.** Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity shall be considered as income, and the payment shall be used to reduce the state supplementary assistance payment.

**441—51.3(249) Eligibility for residential care.**

**51.3(1) Licensed facility.** Payment for residential care shall be made only when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections and appeals pursuant to laws governing health care facilities.

**51.3(2) Physician's statement.** Payment for residential care shall be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification shall be updated whenever a change in the recipient's physical condition warrants reevaluation, but no less than every 12 months.

**51.3(3) Income eligibility.** The resident shall be income eligible when the income according to 441—paragraph 52.1(3) "a" is less than 31 times the per diem rate of the facility. Partners in a marriage who both enter the same room of the residential care facility in the same month shall be income eligible for the initial month when their combined income according to 441—paragraph 52.1(3) "a" is less than twice the amount of allowed income for one person (31 times the per diem rate of the facility).

**51.3(4) Diversion of income.** Rescinded IAB 5/1/91, effective 7/1/91.

**51.3(5) Resources.** Rescinded IAB 5/1/91, effective 7/1/91.

This rule is intended to implement Iowa Code section 249.3.

**441—51.4(249) Dependent relatives.**

**51.4(1) Income.** Income of a dependent relative shall be less than \$377. When the dependent's income is from earnings, an exemption of \$65 shall be allowed to cover work expense.

**51.4(2) Resources.** The resource limitation for a recipient and a dependent child or parent shall be \$2,000. The resource limitation for a recipient and a dependent spouse shall be \$3,000. The resource limitation for a recipient, spouse, and dependent child or parent shall be \$3,000.

**51.4(3) Living in the home.** A dependent relative shall be eligible until out of the recipient's home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

**51.4(4) Dependency.** A dependent relative may be the recipient's ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative shall not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

[ARC 7605B, IAB 3/11/09, effective 4/15/09; ARC 9965B, IAB 1/11/12, effective 1/1/12; ARC 0064C, IAB 4/4/12, effective 5/9/12; ARC 0489C, IAB 12/12/12, effective 1/1/13; ARC 0633C, IAB 3/6/13, effective 5/1/13; ARC 1268C, IAB 1/8/14, effective 1/1/14; ARC 1352C, IAB 3/5/14, effective 4/9/14; ARC 1813C, IAB 1/7/15, effective 1/1/15]

**441—51.5(249) Residence.** A recipient of state supplementary assistance shall be living in the state of Iowa.

This rule is intended to implement Iowa Code section 249.3.

**441—51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles.** The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

**51.6(1) Medicaid eligibility.** The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spenddown or pay a premium to be eligible for medical assistance benefits.

**51.6(2) SSI eligibility.** The recipient shall meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

**51.6(3) Not otherwise eligible.** The recipient must not be eligible for benefits under another state supplementary assistance group.

**51.6(4) Medicare eligibility.** The recipient must be currently eligible for Medicare Part B.

**51.6(5) Living arrangement.** A recipient may live in one of the following:

- a. The person's own home.
- b. The home of another person.
- c. A group living arrangement.
- d. A medical facility.

**51.6(6) Income.** Income of a recipient shall be within the income limit for the person's Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.

This rule is intended to implement Iowa Code section 249.3 as amended by 2005 Iowa Acts, House File 825, section 108.

**441—51.7(249) Income from providing room and board.** In determining profit from furnishing room and board or providing family life home care, \$377 per month shall be deducted to cover the cost, and the remaining amount treated as earned income.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

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**441—51.8(249) Furnishing of social security number.** As a condition of eligibility applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

**441—51.9(249) Recovery.**

**51.9(1) Definitions.**

*“Administrative overpayment”* means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

*“Agency error”* means assistance incorrectly paid to or for the client because of action attributed to the department as the result of one or more of the following circumstances:

1. Misfiling or loss of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the local office.
6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

*“Client”* means a current or former applicant or recipient of state supplementary assistance.

“*Client error*” means assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. It also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report as defined in rule 441—76.10(249A).

“*Department*” means the department of human services.

**51.9(2)** *Amount subject to recovery.* The department shall recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

*a.* The department also shall seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

*b.* The incorrect expenditures may result from client or agency error, or administrative overpayment.

**51.9(3)** *Notification.* All clients shall be promptly notified when it is determined that assistance was incorrectly expended. Notification shall include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

**51.9(4)** *Source of recovery.* Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

**51.9(5)** *Repayment.* The repayment of incorrectly expended state supplementary assistance funds shall be made to the department.

**51.9(6)** *Appeals.* The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

This rule is intended to implement Iowa Code sections 249.3 and 249.4.

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CHAPTER 52  
PAYMENT

[Prior to 7/1/83, Social Services[770] Ch 52]  
[Prior to 2/11/87, Human Services[498]]

**441—52.1(249) Assistance standards.** Assistance standards are the amounts of money allowed on a monthly basis to recipients of state supplementary assistance in determining financial need and the amount of assistance granted.

**52.1(1) Protective living arrangement.** The following assistance standards have been established for state supplementary assistance for persons living in a family life home certified under rules in 441—Chapter 111.

\$794	Care allowance
<u>\$101</u>	Personal allowance
\$895	Total

**52.1(2) Dependent relative.** The following assistance standards have been established for state supplementary assistance for dependent relatives residing in a recipient’s home.

- a. Aged or disabled client and a dependent relative . . . . . \$1,110
- b. Aged or disabled client, eligible spouse, and a dependent relative . . . . . \$1,477
- c. Blind client and a dependent relative . . . . . \$1,132
- d. Blind client, aged or disabled spouse, and a dependent relative . . . . . \$1,499
- e. Blind client, blind spouse, and a dependent relative . . . . . \$1,521

**52.1(3) Residential care.** Payment to a recipient in a residential care facility shall be made on a flat per diem rate of \$17.86 or on a cost-related reimbursement system with a maximum per diem rate of \$30.05. The department shall establish a cost-related per diem rate for each facility choosing this method of payment according to rule 441—54.3(249).

The facility shall accept the per diem rate established by the department for state supplementary assistance recipients as payment in full from the recipient and make no additional charges to the recipient.

a. All income of a recipient as described in this subrule after the disregards described in this subrule shall be applied to meet the cost of care before payment is made through the state supplementary assistance program.

Income applied to meet the cost of care shall be the income considered available to the resident pursuant to supplemental security income (SSI) policy plus the SSI benefit less the following monthly disregards applied in the order specified:

- (1) When income is earned, impairment related work expenses, as defined by SSI plus \$65 plus one-half of any remaining earned income.
- (2) An allowance of \$101 to meet personal expenses and Medicaid copayment expenses.
- (3) When there is a spouse at home, the amount of the SSI benefit for an individual minus the spouse’s countable income according to SSI policies. When the spouse at home has been determined eligible for SSI benefits, no income disregard shall be made.
- (4) When there is a dependent child living with the spouse at home who meets the definition of a dependent according to the SSI program, the amount of the SSI allowance for a dependent minus the dependent’s countable income and the amount of income from the parent at home that exceeds the SSI benefit for one according to SSI policies.
- (5) Established unmet medical needs of the resident, excluding private health insurance premiums and Medicaid copayment expenses. Unmet medical needs of the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall be an additional deduction when the countable income of the spouse at home is not sufficient to cover those expenses. Unmet medical needs of the dependent living with the spouse at home, exclusive of health insurance premiums and Medicaid copayment expenses, shall also be deducted when the countable income of the dependent and the income of the parent at home that exceeds the SSI benefit for one is not sufficient to cover the expenses.

(6) The income of recipients of state supplementary assistance or Medicaid needed to pay the cost of care in another residential care facility, a family life home, an in-home health-related care provider, a home- and community-based waiver setting, or a medical institution is not available to apply to the cost of care. The income of a resident who lived at home in the month of entry shall not be applied to the cost of care except to the extent the income exceeds the SSI benefit for one person or for a married couple if the resident also had a spouse living in the home in the month of entry.

*b.* Payment is made for only the days the recipient is a resident of the facility. Payment shall be made for the date of entry into the facility, but not the date of death or discharge.

*c.* Payment shall be made in the form of a grant to the recipient on a post payment basis.

*d.* Payment shall not be made when income is sufficient to pay the cost of care in a month with less than 31 days, but the recipient shall remain eligible for all other benefits of the program.

*e.* Payment will be made for periods the resident is absent overnight for the purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 30 days during any calendar year, unless a family member or legal guardian of the resident, the resident's physician, case manager, or department service worker provides signed documentation that additional visitation days are desired by the resident and are for the benefit of the resident. This documentation shall be obtained by the facility for each period of paid absence which exceeds the 30-day annual limit. This information shall be retained in the resident's personal file. If documentation is not available to justify periods of absence in excess of the 30-day annual limit, the facility shall submit a Case Activity Report, Form 470-0042, to the county office of the department to terminate the state supplementary assistance payment.

A family member may contribute to the cost of care for a resident subject to supplementation provisions at rule 441—51.2(249) and any contributions shall be reported to the county office of the department by the facility.

*f.* Payment will be made for a period not to exceed 20 days in any calendar month when the resident is absent due to hospitalization. A resident may not start state supplementary assistance on reserve bed days.

*g.* The per diem rate established for recipients of state supplementary assistance shall not exceed the average rate established by the facility for private pay residents.

(1) Residents placed in a facility by another governmental agency are not considered private paying individuals. Payments received by the facility from such an agency shall not be included in determining the average rate for private paying residents.

(2) To compute the facilitywide average rate for private paying residents, the facility shall accumulate total monthly charges for those individuals over a six-month period and divide by the total patient days care provided to this group during the same period of time.

**52.1(4) *Blind.*** The standard for a blind recipient not receiving another type of state supplementary assistance is \$22 per month.

**52.1(5) *In-home, health-related care.*** Payment to a person receiving in-home, health-related care shall be made in accordance with rules in 441—Chapter 177.

**52.1(6) *Minimum income level cases.*** The income level of those persons receiving old age assistance, aid to the blind, and aid to the disabled in December 1973 shall be maintained at the December 1973 level as long as the recipient's circumstances remain unchanged and that income level is above current standards. In determining the continuing eligibility for the minimum income level, the income limits, resource limits, and exclusions which were in effect in October 1972 shall be utilized.

**52.1(7) *Supplement for Medicare and Medicaid eligibles.*** Payment to a person eligible for the supplement for Medicare and Medicaid eligibles shall be \$1 per month.

This rule is intended to implement Iowa Code chapter 249.

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CHAPTER 77  
CONDITIONS OF PARTICIPATION FOR PROVIDERS  
OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]

[Prior to 2/11/87, Human Services[498]]

**441—77.1(249A) Physicians.** All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

**441—77.2(249A) Retail pharmacies.** Retail pharmacies are eligible to participate if they meet the requirements of this rule.

**77.2(1) *Licensure.*** Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

**77.2(2) *Survey participation.*** As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

*a.* A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

*b.* A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

*c.* Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[ARC 0485C, IAB 12/12/12, effective 2/1/13]

**441—77.3(249A) Hospitals.**

**77.3(1) *Qualifications.*** All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

**77.3(2) *Referral to health home services provider.*** As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0198C, IAB 7/11/12, effective 7/1/12]

**441—77.4(249A) Dentists.** All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

**441—77.5(249A) Podiatrists.** All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

**441—77.6(249A) Optometrists.** All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

**441—77.7(249A) Opticians.** All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

**441—77.8(249A) Chiropractors.** All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

**441—77.9(249A) Home health agencies.** Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

**77.9(1) Definitions.**

“*Assets*” includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

“*Rider*” means a notice issued by a surety that a change in the bond has occurred or will occur.

“*Uncollected overpayment*” means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

**77.9(2) Parties to surety bonds.** The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety’s name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company’s liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

**77.9(3) Surety company obligations.** The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

**77.9(4) Surety bond requirements.** Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

*b. Amount of bond.* Bonds for any period shall be in the amount of \$50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of \$50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

*c. Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

**77.9(5)** *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

**77.9(6)** *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

**441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies.** All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

**441—77.11(249A) Ambulance service.** Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

**441—77.12(249A) Behavioral health intervention.** A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9487B, IAB 5/4/11, effective 7/1/11]

**441—77.13(249A) Hearing aid dispensers.** Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.14(249A) Audiologists.** Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.15(249A) Community mental health centers.** Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.16(249A) Screening centers.** Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.17(249A) Physical therapists.** Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.18(249A) Orthopedic shoe dealers and repair shops.** Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.19(249A) Rehabilitation agencies.** Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

This rule is intended to implement Iowa Code section 249A.4.

**441—77.20(249A) Independent laboratories.** Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.21(249A) Rural health clinics.** Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

**441—77.22(249A) Psychologists.** All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

**441—77.23(249A) Maternal health centers.** A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.24(249A) Ambulatory surgical centers.** Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program

if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

**441—77.25(249A) Home- and community-based habilitation services.** To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health and meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

**77.25(1) Definitions.**

“Guardian” means a guardian appointed in probate or juvenile court.

“Major incident” means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

“Member” means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

“Minor incident” means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

**77.25(2) Organization and staff.**

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

**77.25(3) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member’s file.

b. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

- (1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

*c. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.25(4) Restraint, restriction, and behavioral intervention.** The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

*a.* The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

*b.* Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

*c.* Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

*d.* Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

*e.* Corporal punishment and verbal or physical abuse are prohibited.

**77.25(5) Case management.** The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

**77.25(6) Day habilitation.** The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph "a," "d," "g," or "h."

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

**77.25(7) Home-based habilitation.** The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic

mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

**77.25(8) *Prevocational habilitation.*** The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

**77.25(9) *Supported employment habilitation.*** The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

**77.25(10) *Provider enrollment.*** A prospective provider that meets the criteria in this rule and the provider criteria of the Iowa Plan for Behavioral Health contractor must be enrolled through the Iowa Plan for Behavioral Health contractor as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. The Iowa Medicaid enterprise will enroll providers with Medicaid only when the provider is enrolled in the Iowa Plan for Behavioral Health. Payment for services will be made to a provider only when the provider is enrolled in the Iowa Plan for Behavioral Health and the provider is authorized to provide the services. This includes payments made by the Iowa Medicaid enterprise for services provided to members who are not eligible to enroll in the Iowa Plan for Behavioral Health.

a. The Iowa Plan for Behavioral Health contractor shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department or the Iowa Plan for Behavioral Health contractor may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13]

**441—77.26(249A) Behavioral health services.** The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

**77.26(1) Licensed marital and family therapists (LMFT).** Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

**77.26(2) Licensed independent social workers (LISW).** Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

**77.26(3) Licensed master social workers (LMSW).**

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

**77.26(4) Licensed mental health counselors (LMC).** Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

**77.26(5) Certified alcohol and drug counselors.** Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[ARC 9649B, IAB 8/10/11, effective 8/1/11]

**441—77.27(249A) Birth centers.** Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.28(249A) Area education agencies.** An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

**77.28(1)** Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

**77.28(2)** Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

**77.28(3)** Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

**77.28(4)** Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(3);
- b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
- c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
- d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

**77.28(5)** Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

**77.28(6)** Personnel providing vision services shall be:

- a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
- b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 1807C, IAB 1/7/15, effective 3/1/15]

**441—77.29(249A) Case management provider organizations.** Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

**77.29(1) Standards in 441—Chapter 24.** Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

**77.29(2) Standards in 441—Chapter 186.** Rescinded IAB 10/12/05, effective 10/1/05.

**441—77.30(249A) HCBS health and disability waiver service providers.** HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

**77.30(1) Homemaker providers.** Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.30(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.30(3) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.30(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.30(5) Respite care providers.**

a. The following agencies may provide respite services:

- (1) Home health agencies that are certified to participate in the Medicare program.
- (2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
- (3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (5) Camps certified by the American Camping Association.
- (6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).
- (8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
  1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
  2. An emergency medical care release.
  3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
  4. The consumer's medical issues, including allergies.
  5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver

and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.30(6) Counseling providers.** Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.30(7) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.30(8) Interim medical monitoring and treatment providers.**

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.30(9) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.30(10) *Personal emergency response system providers.*** Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

**77.30(11) *Home-delivered meals.*** The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.30(12) *Nutritional counseling.*** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians approved by an area agency on aging.

**77.30(13) *Financial management service.*** Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

**77.30(14) *Independent support brokerage.*** Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

*f.* The broker must complete independent support brokerage training approved by the department.

**77.30(15) *Self-directed personal care.*** Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

*a.* A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

*b.* An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

*c.* All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

*d.* The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(16) *Individual-directed goods and services.*** Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

*a.* A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

*b.* An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

*c.* All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

*d.* The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(17) *Self-directed community supports and employment.*** Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

*a.* A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

*b.* An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

*c.* All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

*d.* The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

**77.30(18) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

*a. Definitions.*

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14]

**441—77.31(249A) Occupational therapists.** Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

**77.31(1)** Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.31(2)** Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.32(249A) Hospice providers.** Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.33(249A) HCBS elderly waiver service providers.** HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

**77.33(1) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.33(2) Emergency response system providers.** Emergency response system providers must meet the following standards:

*a.* The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

*b.* The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

*c.* There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

*d.* The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

*e.* There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

**77.33(3) Home health aide providers.** Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

**77.33(4) Homemaker providers.** Homemaker providers shall be agencies that are:

*a.* Certified as a home health agency under Medicare, or

*b.* Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.33(5) Nursing care.** Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

**77.33(6) Respite care providers.**

*a.* The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.33(7) *Chore providers.*** The following providers may provide chore services:

*a.* Home health agencies certified under Medicare.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

*f.* Community businesses that are engaged in the provision of chore services and that:

- (1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

- (2) Submit verification of current liability and workers' compensation coverage.

**77.33(8) *Home-delivered meals.*** The following providers may provide home-delivered meals:

*a.* Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

- d. Restaurants licensed and inspected under Iowa Code chapter 137F.
- e. Hospitals enrolled as Medicaid providers.
- f. Home health aide providers meeting the standards set forth in subrule 77.33(3).
- g. Medical equipment and supply dealers certified to participate in the Medicaid program.
- h. Home care providers meeting the standards set forth in subrule 77.33(4).

**77.33(9) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

- a. Area agencies on aging as designated in 17—4.4(231).
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

**77.33(10) Mental health outreach providers.** Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

**77.33(11) Transportation providers.** The following providers may provide transportation:

- a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Regional transit agencies as recognized by the Iowa department of transportation.
- d. Rescinded IAB 3/10/99, effective 5/1/99.
- e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- f. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.33(12) Nutritional counseling.** The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

- a. Hospitals enrolled as Medicaid providers.
- b. Community action agencies as designated in Iowa Code section 216A.93.
- c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.
- d. Home health agencies certified by Medicare.
- e. Independent licensed dietitians.

**77.33(13) Assistive device providers.** The following providers may provide assistive devices:

- a. Medicaid-enrolled medical equipment and supply dealers.
- b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

**77.33(14) Senior companions.** Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

**77.33(15) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide attendant care service and who is:
  - (1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.33(16) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.33(17) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.33(18) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.33(19) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.33(20) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.33(21) *Case management providers.*** A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

*a.* The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and

2. Provides a current IDPH local public health services contract number.

*b.* A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both

case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

- (1) Specific procedures to identify conflicts of interest.
- (2) Procedures to eliminate any conflict of interest that is identified.
- (3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

- (1) That entity must also meet the provider qualifications in this subrule; and
- (2) The contractor is responsible for verification of compliance.

**77.33(22) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. *Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“Minor incident” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. *Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

c. *Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.33(23) Assisted living on-call service.** Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

**441—77.34(249A) HCBS AIDS/HIV waiver service providers.** HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

**77.34(1) Counseling providers.** Counseling providers shall be:

*a.* Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

*b.* Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

**77.34(2) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program.

**77.34(3) Homemaker providers.** Homemaker providers shall be agencies that are:

- a. Certified as a home health agency under Medicare, or
- b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

**77.34(4) Nursing care providers.** Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

**77.34(5) Respite care providers.**

- a. The following agencies may provide respite services:
  - (1) Home health agencies that are certified to participate in the Medicare program.
  - (2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.
  - (3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.
  - (4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
  - (5) Camps certified by the American Camping Association.
  - (6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).
  - (7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).
  - (8) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
  - (1) Providers shall maintain the following information that shall be updated at least annually:
    1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
    2. An emergency medical care release.
    3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
    4. The consumer's medical issues, including allergies.
    5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
  - (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.34(6) Home-delivered meals.** The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

**77.34(7) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.34(8) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.34(9) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.34(10) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.34(11) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.34(12) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.34(13) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

**77.34(14) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

*a. Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician’s treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. **EXCEPTION:** Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.
- (3) The following information shall be reported:
  1. The name of the consumer involved.
  2. The date and time the incident occurred.
  3. A description of the incident.
  4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
  5. The action that the provider staff took to manage the incident.
  6. The resolution of or follow-up to the incident.
  7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14]

**441—77.35(249A) Federally qualified health centers.** Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.36(249A) Advanced registered nurse practitioners.** Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

**77.36(1)** Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

**77.36(2)** Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

**77.36(3)** Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.37(249A) Home- and community-based services intellectual disability waiver service providers.** Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)“a”(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules

77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

**77.37(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

- a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.
- b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.
- c. The organization establishes and maintains fiscal accountability.
- d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.
- e. The organization provides needed training and supports to its staff. This training includes at a minimum:
  - (1) Consumer rights.
  - (2) Confidentiality.
  - (3) Provision of consumer medication.
  - (4) Identification and reporting of child and dependent adult abuse.
  - (5) Individual consumer support needs.
- f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:
  - (1) Measures and assesses organizational activities and services annually.
  - (2) Gathers information from consumers, family members, and staff.
  - (3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).
  - (4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.
  - (5) Identifies areas in need of improvement.
  - (6) Develops a plan to address the areas in need of improvement.
  - (7) Implements the plan and documents the results.
- g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.
- h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.
- i. The governing body has an active role in the administration of the agency.
- j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.37(2) Rights and dignity.** Outcome-based standards for rights and dignity are as follows:

- a. (Outcome 2) Consumers are valued.

- b. (Outcome 3) Consumers live in positive environments.
- c. (Outcome 4) Consumers work in positive environments.
- d. (Outcome 5) Consumers exercise their rights and responsibilities.
- e. (Outcome 6) Consumers have privacy.
- f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.
- g. (Outcome 8) Consumers decide which personal information is shared and with whom.
- h. (Outcome 9) Consumers make informed choices about where they work.
- i. (Outcome 10) Consumers make informed choices on how they spend their free time.
- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

**77.37(3) *Contracts with consumers.*** The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

**77.37(4) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.37(5) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

**77.37(6) *Research.*** If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

**77.37(7) *Abuse reporting requirements.*** The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

**77.37(8) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. *Definitions.*

“*Major incident*” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or
7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until

the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.37(9) Intake, admission, service coordination, discharge, and referral.**

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

*b.* The provider shall ensure the rights of persons applying for services.

**77.37(10) Certification process.** Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

*a.* Rescinded IAB 9/1/04, effective 11/1/04.

*b.* Rescinded IAB 9/1/04, effective 11/1/04.

*c.* Rescinded IAB 9/1/04, effective 11/1/04.

*d.* The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.37(11) Initial certification.** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

*a.* The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

*b.* The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

*c.* Providers applying for initial certification shall be offered technical assistance.

**77.37(12) Period of certification.** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*a.* Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

*b.* Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and

significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the

notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

*e.* As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

*f.* The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

*g.* The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)"*e.*"

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)"*f.*"

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)"*h.*"

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

*h.* An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

*i.* Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

*j.* Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.37(13) Review of providers.** Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

*a.* This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

*b.* A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

*c.* The on-site review team will consist of designated members of the HCBS staff.

*d.* Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

*e.* The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

*f.* Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be

implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

*g.* The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)“*e*” and 77.37(13)“*f*.”

*h.* The department may conduct a site visit to verify all or part of the information submitted.

**77.37(14) Supported community living providers.**

*a.* The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

*b.* Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

*c.* Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

*d.* All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.
2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.37(15) Respite care providers.**

*a.* The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer’s home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

- (9) Assisted living programs certified by the department of inspections and appeals.
- b. Respite providers shall meet the following conditions:
- (1) Providers shall maintain the following information that shall be updated at least annually:
1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
  2. An emergency medical care release.
  3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
  4. The consumer's medical issues, including allergies.
  5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.
- All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.
- In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.
- (3) Policies shall be developed for:
1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
  2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
  3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
  4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.
- c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.
- d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.
- 77.37(16) Supported employment providers.**
- a. The following agencies may provide supported employment services:
- (1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.
  - (2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.
  - (3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.
  - (4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.
  - (5) An agency that is accredited by the International Center for Clubhouse Development.
- b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:
- (1) Member vacation, sick leave and holiday compensation.
  - (2) Procedures for payment schedules and pay scale.
  - (3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.37(17) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.37(18) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

**77.37(19) Nursing providers.** Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

**77.37(20) Home health aide providers.** Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

**77.37(21) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.37(22) Interim medical monitoring and treatment providers.**

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.37(23)** *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues. Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.

- Children are a part of family and community life and perform varied social roles.

- Children have family connections, a social network, and varied relationships.

- Children develop and accomplish personal goals.

- Children are valued.

- Children live in positive environments.

- Children exercise their rights and responsibilities.

- Children make informed choices about how they spend their free time.

- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.

- Current functioning is evaluated.

- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

*d.* As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.

2. Goals to be achieved to meet the needs of the child.

3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

*e.* The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

- (1) Rescinded IAB 8/7/02, effective 10/1/02.
- (2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

- (3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
  2. What physical change will need to take place in the living units.
  3. How children and their families will be involved in the transitioning process.
  4. How this transition will affect children's social and educational environment.
- f.* Certification process and review of service providers.

- (1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

- (2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

- (3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13) "e" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13) "f" and numbered paragraph 77.37(23) "f"(3) "4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13) "h" and subparagraph 77.37(23) "f"(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

**77.37(24) Transportation service providers.** The following providers may provide transportation:

- a. Accredited providers of home- and community-based services.
- b. Regional transit agencies as recognized by the Iowa department of transportation.
- c. Transportation providers that contract with county governments.
- d. Community action agencies as designated in Iowa Code section 216A.93.
- e. Nursing facilities licensed under Iowa Code chapter 135C.
- f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.
- g. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.37(25) Adult day care providers.** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.37(26) Prevocational services providers.** Providers of prevocational services must be accredited by one of the following:

- a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
- b. The Council on Quality and Leadership.

**77.37(27) Day habilitation providers.** Day habilitation services may be provided by:

- a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).
- b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current

accreditation expires. When the current accreditation expires, the agency must qualify under paragraph “a” or “d.”

*c.* Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

*d.* Agencies accredited by the Council on Quality and Leadership.

*e.* Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

**77.37(28) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.37(29) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.37(30) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.37(31) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.37(32) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1149C, IAB 10/30/13, effective 1/1/14]

**441—77.38(249A) *Assertive community treatment.*** Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

**77.38(1) *Minimum composition.*** At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

**77.38(2) *Psychiatrists.*** A psychiatrist on the team shall be a physician (MD or DO) who:

- a.* Is licensed under 653—Chapter 9,
- b.* Is certified as a psychiatrist by the American Board of Medical Specialties’ Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and
- c.* Has experience treating serious and persistent mental illness.

**77.38(3) *Registered nurses.*** A nurse on the team shall:

- a.* Be licensed as a registered nurse under 655—Chapter 3, and
- b.* Have experience treating persons with serious and persistent mental illness.

**77.38(4) *Mental health service providers.*** A mental health service provider on the team shall be:

- a.* A mental health counselor or marital and family therapist who:
  - (1) Is licensed under 645—Chapter 31, and
  - (2) Has experience treating persons with serious and persistent mental illness; or
- b.* A social worker who:
  - (1) Is licensed as a master or independent social worker under 645—Chapter 280, and
  - (2) Has experience treating persons with serious and persistent mental illness.

**77.38(5) *Psychologists.*** A psychologist on the team shall:

- a.* Be licensed under 645—Chapter 240, and
- b.* Have experience treating persons with serious and persistent mental illness.

**77.38(6) Substance abuse treatment professionals.** A substance abuse treatment professional on the team shall:

- a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)“i,” and
- b. Have at least three years of experience treating substance abuse.

**77.38(7) Peer specialists.** A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

**77.38(8) Community support specialists.** A community support specialist on the team shall be a person who:

- a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and
- b. Has experience supporting persons with serious and persistent mental illness.

**77.38(9) Case managers.** A case manager on the team shall be a person who:

- a. Has a bachelor’s degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),
- b. Has experience managing care for persons with serious and persistent mental illness, and
- c. Meets the qualifications of “qualified case managers and supervisors” in rule 441—24.1(225C).

**77.38(10) Advanced registered nurse practitioners.** An advanced registered nurse practitioner on the team shall:

- a. Be licensed under 655—Chapter 7,
- b. Have a mental health certification, and
- c. Have experience treating serious and persistent mental illness.

**77.38(11) Physician assistants.** A physician assistant on the team shall:

- a. Be licensed under 645—Chapter 326,
- b. Have experience treating persons with serious and persistent mental illness, and
- c. Practice under the supervision of a psychiatrist.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

**441—77.39(249A) HCBS brain injury waiver service providers.** Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department’s brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

**77.39(1) Organizational standards (Outcome 1).** Organizational outcome-based standards for HCBS BI providers are as follows:

*a.* The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

*b.* The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

*c.* The organization establishes and maintains fiscal accountability.

*d.* The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

*e.* The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

*f.* The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

*g.* Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

*h.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

*i.* The governing body has an active role in the administration of the agency.

*j.* The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

**77.39(2) Rights and dignity.** Outcome-based standards for rights and dignity are as follows:

*a.* (Outcome 2) Consumers are valued.

*b.* (Outcome 3) Consumers live in positive environments.

*c.* (Outcome 4) Consumers work in positive environments.

*d.* (Outcome 5) Consumers exercise their rights and responsibilities.

*e.* (Outcome 6) Consumers have privacy.

*f.* (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

*g.* (Outcome 8) Consumers decide which personal information is shared and with whom.

*h.* (Outcome 9) Consumers make informed choices about where they work.

*i.* (Outcome 10) Consumers make informed choices on how they spend their free time.

- j. (Outcome 11) Consumers make informed choices about where and with whom they live.
- k. (Outcome 12) Consumers choose their daily routine.
- l. (Outcome 13) Consumers are a part of community life and perform varied social roles.
- m. (Outcome 14) Consumers have a social network and varied relationships.
- n. (Outcome 15) Consumers develop and accomplish personal goals.
- o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.
- p. (Outcome 17) Consumers maintain good health.
- q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.
- r. (Outcome 19) The consumer's desire for intimacy is respected and supported.
- s. (Outcome 20) Consumers have an impact on the services they receive.

**77.39(3) *The right to appeal.*** Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

**77.39(4) *Storage and provision of medication.*** If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

**77.39(5) *Research.*** If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

**77.39(6) *Incident management and reporting.*** As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. **EXCEPTION:** The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

*a. Definitions.*

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's

supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.39(7)** *Intake, admission, service coordination, discharge, and referral.*

*a.* The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

*b.* The provider shall ensure the rights of persons applying for services.

**77.39(8)** *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

*a.* Rescinded IAB 9/1/04, effective 11/1/04.

*b.* Rescinded IAB 9/1/04, effective 11/1/04.

*c.* Rescinded IAB 9/1/04, effective 11/1/04.

*d.* The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.39(9) Initial certification.** The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

*a.* The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

*b.* The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

*c.* Providers applying for initial certification shall be offered technical assistance.

**77.39(10) Period of certification.** Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*a.* Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

*b.* Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

*c.* The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probationary certification.* A probationary certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probationary certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

*d.* During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

*e.* As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

*f.* The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

*g.* The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11) "d."

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11) "e."

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11) "f."

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

*h.* An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

*i.* Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

*j.* Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

**77.39(11) Departmental reviews.** Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

*a.* Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

*b.* Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

*c.* The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

*d.* The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

*e.* The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11) "c" and "d."

*f.* The department may conduct a site visit to verify all or part of the information submitted.

**77.39(12) Case management service providers.** Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

**77.39(13) Supported community living providers.**

*a.* The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

*b.* Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

*c.* Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

*d.* The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

*e.* The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

*f.* The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

**77.39(14) Respite service providers.** Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

*a.* The following agencies may provide respite services:

- (1) Respite providers certified under the HCBS intellectual disability waiver.
- (2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).
- (3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.
- (4) Camps certified by the American Camping Association.
- (5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).
- (6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.
- (7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.
- (8) Home health agencies that are certified to participate in the Medicare program.
- (9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).
- (10) Assisted living programs certified by the department of inspections and appeals.

*b.* Respite providers shall meet the following conditions:

- (1) Providers shall maintain the following information that shall be updated at least annually:
  1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
  2. An emergency medical care release.
  3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
  4. The consumer's medical issues, including allergies.
  5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.
- (2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

*c.* A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

*d.* Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

**77.39(15) Supported employment providers.**

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

**77.39(16) Home and vehicle modification providers.** The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.39(17) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

**77.39(18) Transportation service providers.** This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

**77.39(19) Specialized medical equipment providers.** The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

**77.39(20) *Adult day care providers.*** Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

**77.39(21) *Family counseling and training providers.*** Family counseling and training providers shall be one of the following:

*a.* Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*b.* Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*c.* Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*d.* Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

*e.* Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

**77.39(22) *Prevocational services providers.*** Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

**77.39(23) *Behavioral programming providers.*** Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

*a.* Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

*b.* Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

**77.39(24) *Consumer-directed attendant care providers.*** The following providers may provide consumer-directed attendant care service:

*a.* An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

*b.* Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

*c.* Home health agencies which are certified to participate in the Medicare program.

*d.* Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

*e.* Community action agencies as designated in Iowa Code section 216A.93.

*f.* Providers certified under an HCBS waiver for supported community living.

*g.* Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

*h.* Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.39(25) *Interim medical monitoring and treatment providers.***

*a.* The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

*b.* Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

*c.* Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

**77.39(26) *Financial management service.*** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.39(27) *Independent support brokerage.*** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.39(28) *Self-directed personal care.*** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.39(29) *Individual-directed goods and services.*** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.39(30) *Self-directed community supports and employment.*** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 1638C**, IAB 10/1/14, effective 11/5/14]

**441—77.40(249A) Lead inspection agencies.** The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.41(249A) HCBS physical disability waiver service providers.** Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

**77.41(1) Enrollment process.** Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

- a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.
- b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

**77.41(2) Consumer-directed attendant care providers.** The following providers may provide consumer-directed attendant care service:

- a. An individual who contracts with the member to provide consumer-directed attendant care and who is:
  - (1) At least 18 years of age.
  - (2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.
  - (3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.
  - (4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.
- b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.
- c. Home health agencies that are certified to participate in the Medicare program.
- d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.
- e. Community action agencies as designated in Iowa Code section 216A.103.
- f. Providers certified under an HCBS waiver for supported community living.
- g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.
- h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

**77.41(3) Home and vehicle modification providers.** The following providers may provide home and vehicle modifications:

*a.* Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

*b.* Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

**77.41(4) Personal emergency response system providers.** Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

**77.41(5) Specialized medical equipment providers.** The following providers may provide specialized medical equipment:

*a.* Medical equipment and supply dealers participating as providers in the Medicaid program.

*b.* Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

**77.41(6) Transportation service providers.** The following providers may provide transportation:

*a.* Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

*b.* Community action agencies as designated in Iowa Code section 216A.93.

*c.* Regional transit agencies as recognized by the Iowa department of transportation.

*d.* Nursing facilities licensed pursuant to Iowa Code chapter 135C.

*e.* Transportation providers contracting with the nonemergency medical transportation contractor.

**77.41(7) Financial management service.** Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

**77.41(8) Independent support brokerage.** Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

**77.41(9) Self-directed personal care.** Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

**77.41(10) Individual-directed goods and services.** Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

**77.41(11) Self-directed community supports and employment.** Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

**77.41(12) Incident management and reporting.** As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

*a. Definitions.*

“Major incident” means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or

7. Involves a consumer’s location being unknown by provider staff who are assigned protective oversight.

“*Minor incident*” means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

*b. Reporting procedure for minor incidents.* Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member’s supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*c. Reporting procedure for major incidents.* When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member’s supervisor.
2. The consumer or the consumer’s legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider’s service provision. Notification to the guardian, if any, is always required.
3. The consumer’s case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer’s file.

*d. Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 1071C, IAB 10/2/13, effective 10/1/13]

**441—77.42(249A) Public health agencies.** Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

This rule is intended to implement Iowa Code section 249A.4.

[ARC 0358C, IAB 10/3/12, effective 11/7/12]

**441—77.43(249A) Infant and toddler program providers.** An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

**77.43(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

*a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

*b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

*c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

*d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

*e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

*f.* Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

*g.* Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

- h.* Medical transportation shall be provided by licensed drivers.
- i.* Other services shall be provided by staff who are:
  - (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
  - (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
  - (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
  - (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
  - (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
  - (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
  - (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
  - (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
  - (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
  - (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.43(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

- a.* Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b.* An assessment and response to interventions and services.
- c.* An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).
- d.* Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

This rule is intended to implement Iowa Code section 249A.4.

**441—77.44(249A) Local education agency services providers.** School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

**77.44(1) Licensure.** Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

*a.* Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

*b.* Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

*c.* Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

*d.* Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

- (1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
- (2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;
- (3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;
- (4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- (5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

*e.* Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

*f.* Personnel providing vision services shall be:

- (1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;
- (2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or
- (3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

*g.* Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

*h.* Medical transportation shall be provided by licensed drivers.

*i.* Other services shall be provided by staff who are:

- (1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);
- (2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);
- (3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);
- (4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);
- (5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);
- (6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);
- (7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);
- (8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);
- (9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or
- (10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

**77.44(2) Documentation requirements.** As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

- a.* Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.
- b.* An assessment and response to interventions and services.
- c.* Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

This rule is intended to implement Iowa Code section 249A.4.

**441—77.45(249A) Indian health service 638 facilities.** A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

**77.45(1) Licensure.** Services must be rendered by practitioners who meet applicable professional licensure requirements.

**77.45(2) Documentation.** Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

This rule is intended to implement Iowa Code section 249A.4.

**441—77.46(249A) HCBS children's mental health waiver service providers.** HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

**77.46(1) General provider standards.** All providers of HCBS children's mental health waiver services shall meet the following standards:

*a. Fiscal capacity.* Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

*b. Direct care staff.*

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

*c. Outcome-based standards and quality assurance.*

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.

2. Consumers are a part of community life.

3. Consumers develop meaningful goals.

4. Consumers maintain physical and mental health.

5. Consumers are safe.

6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

*d. Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION:

The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

*"Major incident"* means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

*"Minor incident"* means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

**77.46(2)** *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

**77.46(3)** *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)“c” for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

- (1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.
- (2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.
- (3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.
- (4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(4) In-home family therapy providers.**

*a. Qualified providers.* The following agencies may provide in-home family therapy under the children's mental health waiver:

- (1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.
- (2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

- (1) Within one month of employment, staff members must receive the following training:
  1. Orientation regarding the agency's mission, policies, and procedures; and
  2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1) "c" for the children's mental health waiver.
- (2) Within four months of employment, staff members must receive training regarding the following:
  1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;
  2. Confidentiality;
  3. Provision of medication according to agency policy and procedure;
  4. Identification and reporting of child abuse;
  5. Incident reporting;
  6. Documentation of service provision;
  7. Appropriate behavioral interventions; and
  8. Professional ethics.
- (3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.
- (4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.
- (5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in

441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*d. Intake, admission, and discharge.* As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

**77.46(5) Respite care providers.**

*a. Qualified providers.* The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

*b. Staff training.* The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1) "c."

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

*c. Consumer-specific information.* The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

*d. Written notification of injury.* The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

*e. Medication dispensing.* Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

*f. Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

*g. Service documentation.* Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

*h. Capacity.* A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

*i. Service provided outside home or facility.* For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7936B, IAB 7/1/09, effective 9/1/09; ARC 9314B, IAB 12/29/10, effective 3/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 1149C, IAB 10/30/13, effective 1/1/14]

**441—77.47(249A) Health home services providers.** Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

**77.47(1) Qualifications.** A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

*a. Staffing.* At a minimum, a qualifying provider must fill the following roles:

- (1) Designated practitioner.
- (2) Dedicated care coordinator.
- (3) Health coach.
- (4) Clinic support staff.

*b. Data management.* A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

*c. Collaboration with case managers.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

*d. Provision of integrated health home services.* Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)“a”(3) or (4) must be integrated health homes that:

- (1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);
- (2) Have a direct agreement with the Iowa Medicaid managed behavioral health organization to provide health home services for members with SMI or SED;
- (3) Coordinate all community and social support services needs for members enrolled in the health home; and
- (4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

**77.47(2) Report on quality measures.** As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

**77.47(3) Selection.** As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0838C, IAB 7/24/13, effective 7/1/13]

**441—77.48(249A) Speech-language pathologists.** Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

**77.48(1)** Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

**77.48(2)** Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158. [ARC 0360C, IAB 10/3/12, effective 12/1/12]

**441—77.49(249A) Physician assistants.** All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401, otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4. [ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—77.50(249A) Ordering and referring providers.** A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

This rule is intended to implement Iowa Code section 249A.4. [ARC 0580C, IAB 2/6/13, effective 4/1/13]

**441—77.51(249A) Accountable care organizations.** Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as an accountable care organization (ACO).

**77.51(1) ACO qualifications.** ACO entities must meet the following requirements for participation as an ACO:

*a.* An ACO must be a Medicaid-enrolled provider. An ACO must complete enrollment in accordance with rule 441—79.14(249A).

*b.* The ACO shall execute a provider participation agreement in accordance with rule 441—79.6(249A).

*c.* An ACO must complete Form 470-5264, Iowa Wellness Plan ACO Readiness Application. The department reserves the right to approve the application.

*d.* The department and ACO shall enter into an agreement on Form 470-5218, Iowa Medicaid Accountable Care Organization (ACO) Agreement. The ACO shall comply with all requirements as identified in Form 470-5218.

*e.* The department reserves the right to restrict ACO enrollment so that the mixture of enrolled ACOs best matches the needs of the Medicaid member population.

**77.51(2) Member selection.** Medicaid members eligible for services from providers attributed to an ACO shall be required to choose their providers in accordance with 441—subrules 88.3(2) and 88.3(7).

This rule is intended to implement Iowa Code section 249A.4. [ARC 1698C, IAB 10/29/14, effective 1/1/15]

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CHAPTER 81  
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]  
[Prior to 2/11/87, Human Services[498]]

DIVISION I  
GENERAL POLICIES

**441—81.1(249A) Definitions.**

“*Abuse*” means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“*Advance directive*” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

“*Allowable costs*” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“*Beginning eligibility date*” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“*Case mix*” means a measure of the intensity of care and services used by similar residents in a facility.

“*Case-mix index*” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“*Civil penalty*” shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“*Clinical experience*” means application or learned skills for direct resident care in a nursing facility.

“*Complete replacement*” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“*Cost normalization*” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“*Denial of critical care*” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“*Department*” means the Iowa department of human services.

“*Direct care component*” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants,

rehabilitation nurses, and contracted nursing services. "Direct care component" also includes costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

*"Discharged resident"* means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

*"Facility"* means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

*"Facility-based nurse aide training program"* means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

*"Facility cost report period case-mix index"* is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

*"Facilitywide average case-mix index"* is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

*"Informed consent"* means a resident's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

*"Iowa Medicaid enterprise"* means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

*"Laboratory experience"* means practicing care-giving skills prior to contact in the clinical setting.

*"Level I review"* means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 as amended to July 1, 2014.

*"Level II review"* means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

*"Major renovations"* means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$1.5 million. The \$1.5 million threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility's financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$1.5 million threshold.

*"Medicaid average case-mix index"* is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

*"Minimum data set"* or *"MDS"* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility's case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.6(16)"b," for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.6(16)"c" and "e," the excess payment allowance pursuant to paragraph 81.6(16)"d," and the limits on reimbursement components pursuant to paragraph 81.6(16)"f." MDS is described in subrule 81.13(9).

*"Minimum food, shelter, clothing, supervision, physical or mental health care, or other care"* means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

*"Mistreatment"* means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation

or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

*“New construction”* means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

*“Non-direct care component”* means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report.

*“Non-facility-based nurse aide training program”* means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

*“Nurse aide”* means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

*“Nurse aide registry”* means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

*“Nurse aide training and competency evaluation programs (NATCEP)”* are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

*“PASRR”* means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C, as amended to July 1, 2014.

*“Patient-day-weighted median cost”* means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

*“Physical abuse”* means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

*“Physical injury”* means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

*“Poor performing facility (PPF)”* is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)“o.”

*“Primary instructor”* means a registered nurse responsible for teaching a state-approved nurse aide training course.

*“Program coordinator”* means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

*“Rate determination letter”* means the letter that is distributed quarterly by the Iowa Medicaid enterprise to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

*“Skills performance record”* means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.

3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“*Special population nursing facility*” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 21 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness.

“*Surgical or other invasive procedure*” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. “Surgical or other invasive procedure” does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

“*Terminated from the Medicare or Medicaid program*” means a facility has lost the final appeal to which it is entitled.

“*Testing entity*” means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“a,” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15]

**441—81.2** Rescinded, effective 11/21/79.

**441—81.3(249A) Initial approval for nursing facility care.**

**81.3(1)** *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

*a.* Decisions on level of care, subject to paragraph 81.3(1)“b,” shall be made for the department by the Iowa Medicaid enterprise (IME) medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

*b.* For residents subject to a Level II PASRR review pursuant to subrule 81.3(3), the level of care determination shall be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

*c.* Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 7.

**81.3(2)** *Skilled nursing care level of need.* Rescinded IAB 7/11/01, effective 7/1/01.

**81.3(3)** *Preadmission review.* The department’s contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person’s care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department’s contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

*a.* Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person's attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person's physical condition, and the person is not a danger to self or others. If the person's nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person's illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person's caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and
3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and
4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

*b.* Outcome of Level II review. The Level II review shall determine:

(1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

(2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.13(14) "b," using the procedures set forth in 42 CFR 483.134 as amended to July 1, 2014; and

(3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.13(14) "c," using the procedures set forth in 42 CFR 483.136 as amended to July 1, 2014.

*c.* The department's division of mental health and disability services or its designee shall review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

*d.* Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

- (1) Only if a Level I review was completed prior to admission;
- (2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.3(3)“*a*” has been approved, and it is determined by the division of mental health and disability services that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person’s treatment needs related to a mental illness or intellectual disability will be or are being met.

*e.* Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 7.

*f.* A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident’s lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the nursing facility submits a document providing such resident’s consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident’s knowledge of the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility’s bringing the state fair hearing on the resident’s behalf.

**81.3(4) *Special care level of need.*** Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)“*a*” and 249A.4. [ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

#### **441—81.4(249A) Arrangements with residents.**

**81.4(1) *Resident care agreement.*** Rescinded IAB 12/6/95, effective 2/1/96.

**81.4(2) *Financial participation by resident.*** A resident’s payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident’s client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

**81.4(3) *Personal needs account.*** When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident’s personal needs funds. (See subrule 81.13(5)“*c.*”) The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.6(249A) if the service cannot be obtained free of charge. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident’s personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

*a.* Upon admittance, a ledger sheet shall be credited with the resident’s total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident’s signature. A separate ledger shall be maintained for each resident.

*b.* When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident’s benefit.

*c.* Personal funds shall only be turned over to the resident, the resident’s guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to

purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

*d.* The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

*e.* Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department shall turn the funds over to the estate.

**81.4(4) *Safeguarding personal property.*** The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

*a.* Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

*b.* Providing adequate storage facilities for the resident's personal effects.

*c.* Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives. Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

**441—81.5(249A) Discharge and transfer.** (See subrules 81.13(2) "a" and 81.13(6) "c.")

**81.5(1) *Notice.*** When a public assistance recipient requests transfer or discharge, or another person requests this for the recipient, the administrator shall promptly notify the local office of the department. This shall be done in sufficient time to permit a social service worker to assist in the planning for the transfer or discharge.

**81.5(2) *Case activity report.*** A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

**81.5(3) *Plan.*** The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

**81.5(4) *Transfer records.*** When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

- a.* A transfer form of diagnosis.
- b.* Aid to daily living information.
- c.* Transfer orders.
- d.* Nursing care plan.
- e.* Physician's orders for care.
- f.* The resident's personal records.
- g.* When applicable, the personal needs fund record.
- h.* Resident care review team assessment.

**81.5(5) *Unused client participation.*** When a resident leaves the facility during the month, any unused portion of the resident's client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.

**441—81.6(249A) Financial and statistical report and determination of payment rate.** With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all

facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the Iowa Medicaid enterprise provider cost audit and rate setting unit. All Medicare-certified hospital-based nursing facilities shall submit a copy of their Medicare cost report. These reports shall be based on the following rules.

**81.6(1) *Failure to maintain records.*** Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility may result in the penalties specified in subrule 81.14(1).

**81.6(2) *Accounting procedures.*** Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

*a.* Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

*b.* Costs for patient care services shall be divided into the subcategories of “direct patient care costs” and “support care costs.” Costs associated with food and dietary wages shall be included in the “support care costs” subcategory.

**81.6(3) *Submission of reports.*** All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the Iowa Medicaid enterprise provider cost audit and rate setting unit not later than the last day of the fifth calendar month after the close of the provider’s reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility’s established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider’s records and the annual financial report.

*a.* Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

*b.* The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the Iowa Medicaid enterprise provider cost audit and rate setting unit to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.6(3) “e.”

*c.* If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.6(2).

*d.* For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

*e.* A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective the first day of the sixth month following the provider's fiscal year end and shall remain in effect until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the Iowa Medicaid enterprise provider cost audit and rate setting unit.

*f.* When a nursing facility continues to include in the total costs an item or items which had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the Iowa Medicaid enterprise provider cost audit and rate setting unit can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

*g.* Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

*h.* A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the Iowa Medicaid enterprise cost audit and rate setting unit 60 days prior to the first date of the change.

**81.6(4) *Payment at new rate.***

*a.* Except for state-operated nursing facilities and special population nursing facilities, payment rates shall be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below shall be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, shall be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.6(16). In no case shall the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.6(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case shall the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.6(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

(4) Rescinded IAB 9/8/10, effective 8/12/10.

*b.* The Medicaid payment rate for special population nursing facilities shall be updated annually without a quarterly adjustment.

*c.* The Medicaid payment rate for state-operated nursing facilities shall be updated annually without a quarterly adjustment.

**81.6(5) *Accrual basis.*** Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

**81.6(6) *Census of public assistance recipients.*** Census figures of public assistance recipients shall be obtained on the last day of the month ending the reporting period.

**81.6(7) *Patient days.*** In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

**81.6(8) *Opinion of accountant.*** The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

**81.6(9) *Calculating patient days.*** When calculating patient days, facilities shall use an accumulation method.

*a.* Census information shall be based on a patient's status at midnight at the end of each day.

*b.* When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

**81.6(10) *Revenues.*** Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

*a.* Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinency, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

*b.* Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

*c.* Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services which are included in the medical assistance per diem will not be offset.

*d.* Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

*e.* Laundry revenue shall be applied to laundry expense.

*f.* Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

**81.6(11) *Limitation of expenses.*** Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

*a.* Federal and state income taxes are not allowed as reimbursable costs.

*b.* Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

*c.* Bad debts are not an allowable expense.

*d.* Charity allowances and courtesy allowances are not an allowable expense.

*e.* Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal costs shall be prorated. Amounts which appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility which supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings which provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

*f.* Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

*g.* Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

*h.* A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation shall include all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including, but not limited to, salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include, but are not limited to, costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the Iowa Medicaid enterprise provider cost audit and rate setting unit. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the Iowa Medicaid enterprise provider cost audit and rate setting unit with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.6(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) Effective July 1, 2001, the base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.6(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.6(11)“h”(4) to 81.6(11)“h”(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

*i.* Management fees paid to a related party shall be limited on the same basis as the owner administrator’s salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

*j.* Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, 1983 edition, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 81.6(12).

*k.* Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) "Necessary" requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) "Proper" requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

*l.* Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

*m.* When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be based on the cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses and a reasonable rate of return, not to exceed actual rent payments.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be no more than the amortized cost of the facility as identified in subrule 81.6(12), paragraph "a," plus the landlord's other expenses.

The landlord must be willing to provide documentation of these costs for rental arrangements.

*n.* Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

*o.* Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and

other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.
- (4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. EXCEPTION: Facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met.

Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

*p.* The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36, Division II, shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.6(21)“a.”

*q.* Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5)“d.” The Iowa Medicaid program will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

*r.* Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the Iowa Medicaid enterprise provider cost audit and rate setting unit shall adjust each provider’s reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments shall be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

*s.* Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

*t.* Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

*u.* Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

*v.* Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

**81.6(12) Termination or change of owner:**

*a.* A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department of human services with at least 60 days’ prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change

occurs. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

*b.* No increase in the value of property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

*c.* Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

*d.* In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

*e.* A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

**81.6(13) Amended reports.** The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the Iowa Medicaid enterprise when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

**81.6(14) Payment to new facility.** The payment to a new facility shall be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.6(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component shall be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.6(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal year, rates will be established in accordance with subrule 81.6(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility’s fiscal year.

**81.6(15) *Payment to new owner.*** An existing facility with a new owner shall continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the Iowa Medicaid enterprise provider cost audit and rate setting unit of the date the facility's fiscal year will end.

**81.6(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.*** This subrule provides for the establishment of the modified price-based reimbursement rate. The first step in the rate calculation (paragraph "a") determines the per diem direct care and non-direct care component costs. The second step (paragraph "b") normalizes the per diem direct care component costs to remove cost variations associated with different levels of resident case mix. The third step (paragraph "c") calculates the patient-day-weighted medians for the direct care and non-direct care components that are used in subsequent steps to establish rate component limits and excess payment allowances, if any. The fourth step (paragraph "d") calculates the potential excess payment allowance. The fifth step (paragraph "e") calculates the reimbursement rate, including any applicable capital cost per diem instant relief add-on described in paragraph "h," that is further subjected to the rate component limits, including any applicable enhanced non-direct care rate component limit described in paragraph "h," in step six (paragraph "f"). The seventh step (paragraph "g") calculates the additional reimbursement based on accountability measures available beginning July 1, 2002.

*a.* Calculation of per diem cost. For purposes of calculating the non-state-owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs shall be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost shall be arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001, July 1, 2003, July 1, 2004, July 1, 2005, and every second year thereafter, total reported allowable costs shall be adjusted using the inflation factor specified in subrule 81.6(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state-owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or 85 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.6(7).

*b.* Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.6(19).

*c.* Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median shall be established for both the non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state-owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state-owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.6(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting shall be recalculated. The non-state-owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians shall be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.6(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, shall be inflated to July 1, 2004, using the inflation factor specified in subrule 81.6(18).

*d. Excess payment allowance.*

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area as defined by the Centers for Medicare and Medicaid Services (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state-operated nursing facility patient-day-weighted median.

The wage index factor applied July 1, 2001, through June 30, 2002, shall be 11.46 percent. Beginning July 1, 2002, and thereafter, the wage index factor shall be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan

Statistical Area wage indices as published by the Centers for Medicare and Medicaid Services (CMS) each July. The geographic wage index adjustment shall not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state-operated nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state-operated nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.6(16) "b" times the Medicaid average case-mix index pursuant to subrule 81.6(19). In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.6(16) "a." In no case shall the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

*e.* Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph "d," not to exceed the rate component limits determined by the methodology in paragraph "f."

(1) For non-state-owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.6(19), plus the allowed excess payment allowance as determined by the methodology in paragraph "d."

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph "d" and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph "h."

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities shall be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.6(18), based on the most current financial and statistical report.

*f.* Notwithstanding paragraphs "d" and "e," in no instance shall a rate component exceed the rate component limit defined as follows:

(1) For non-state-operated nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(2) For non-state-operated nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state-operated nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care non-state-operated nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.6(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Effective July 1, 2010, additional reimbursement based on the nursing facility pay-for-performance program is available for non-state-owned facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types shall not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of quality care, a nursing

facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, "direct care staff" is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. "Direct care staff" does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The Iowa Medicaid enterprise shall annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	For SFY 2010, 10/1/09 to 3/31/10; thereafter, July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification

Standard	Measurement Period	Value	Source
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts..	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	3 points	Self-certification
National Accreditation: The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.	For SFY 2010, 10/1/09 to 6/30/10; thereafter, payment period	13 points NOTE: A facility that receives points for this measure does not receive points for any other measures in this subcategory.	Self-certification
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility.  To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74%  7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

## (6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
<p>Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations.</p> <p>If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to July 30, 1999, the facility shall be deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIA list of facilities meeting the standard
<p>Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.</p>	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points NOTE: A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIA list of facilities meeting the standard
Subcategory: Staffing			
<p>Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities.</p> <p>Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours shall be normalized to remove variations in staff hours associated with different levels of resident case mix.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation</p> <p>10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit. The facility cost report period case-mix index shall be used to normalize nursing hours.
<p>Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.</p>	Facility fiscal year ending on or before December 31 of the payment period	<p>5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55%</p> <p>10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%</p>	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

Standard	Measurement Period	Value	Source
<p>Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.</p>	Calendar year ending December 31 of the payment period	5 points	Self-certification
<p>Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility.</p> <p>To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.</p>	For SFY 2010, survey completed between 9/1/08 and 3/31/10; thereafter, survey completed between October 1 and March 31 of the payment period	5 points	Form 470-3891, Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
<p>High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.</p>	12-month period ending September 30 of the payment period	<p>3 points if one-half to one standard deviation below the mean percentage of occurrences</p> <p>5 points if one standard deviation or more below the mean percentage of occurrences</p>	IME medical services unit report based on MDS data as reported by CMS
<p>Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.</p>	12-month period ending September 30 of the payment period	5 points	IME medical services unit report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences  5 points if one standard deviation or more below the mean rate of occurrences	IME medical services unit report based on MDS data as reported by CMS
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures  4 points if the facility receives 13 to 15 points in this subcategory	IME medical services unit report based on MDS data as reported by CMS

## (7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIA list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10%  4 points if Medicaid utilization is more than the median plus 20%	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

## (8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation  4 points if administrative costs percentage is less than the mean less one standard deviation	Form 470-0030, Financial and Statistical Report, as analyzed by IME provider cost audit and rate setting unit

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data shall be drawn from Form 470-4828, Nursing Facility Medicaid Pay-for-Performance Self-Certification Report, submitted by the facility to IME. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to IME on Form 470-3891, Nursing Facility Opinion Survey Transmittal. The department shall request required source reports from the long-term care ombudsman and the department of inspections and appeals (DIA).

(10) Calculation of potential add-on payment. The number of points awarded shall be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

91-100 points            5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department shall request the department of inspections and appeals to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.

2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.

3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections and appeals, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program shall be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the Iowa Medicaid enterprise shall:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.6(16) "g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and

2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, to report the use of any additional payments received for the nursing facility pay-for-performance program. Form 470-4829 is due to the department each year by May 1, beginning May 1, 2011. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department shall publish the results of the nursing facility pay-for-performance program annually.

*h.* Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the Centers for Medicare and Medicaid Services (CMS) and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph “f.”

2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph “f.” The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent for the two-month period before the request for additional reimbursement is submitted. Medicaid utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total licensed bed capacity as reported on the facility’s most current financial and statistical report.

2. The facility meets the accountability measure criteria set forth in paragraph “g,” subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.

3. The facility has documented active participation in a quality of care program.

4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, Des Moines, Iowa 50315. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility’s request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.
  2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).
  3. The period during which the add-on is requested (no more than two years).
  4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)
  5. A copy of the facility's most current depreciation schedule which clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.
  6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:
    - The estimated date the assets will be placed into service;
    - The total estimated depreciable value of the assets;
    - The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;and
    - The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.
  7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days shall be determined using the most current submitted financial and statistical report.
  8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.
  9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.
- (7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:
1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.
  2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).
  3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.
- (8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:
1. The estimated completion date of the project.
  2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.
  3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).
  4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).
- (9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.
1. Effective December 1, 2009, total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the

request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. A reconciliation between the estimated amounts and actual amounts shall be completed as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on shall be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. Effective December 1, 2009, for purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. The recalculated capital cost per diem instant relief add-on shall be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period shall be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid shall be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit shall be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or

2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date shall be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval shall be terminated

effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the Iowa Medicaid enterprise is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or

2. The facility does not make reasonable progress on any plans required for initial qualification; or

3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership shall continue under the new owner. Future reimbursement rates shall be determined pursuant to subrules 81.6(15) and 81.6(16).

**81.6(17) Cost report documentation.** All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility's fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility's fiscal year and the midpoint of the facility's fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

**81.6(18) Inflation factor.** The department shall consider an inflation factor in determining the reimbursement rate. The inflation factor shall be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor.

**81.6(19) Case-mix index calculation.**

a. The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility pursuant to subrule 81.13(9). Standard Version 5.12b case-mix indices developed by CMS shall be the basis for calculating the average case-mix index and shall be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.6(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group shall be translated to the appropriate case-mix index referenced in paragraph "a." From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility shall be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors shall be excluded from both average case-mix index calculations.

**81.6(20) Medicare crossover claims for nursing facility services.**

a. *Definitions.* For purposes of this subrule:

“*Crossover claim*” means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicaid-allowed amount*” means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

“*Medicaid reimbursement*” includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

“*Medicare payment amount*” means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. *Crossover claims.* Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

**81.6(21) Nursing facility quality assurance payments.**

a. *Quality assurance assessment pass-through.* Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. *Quality assurance assessment rate add-on.* Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance add-on of \$10 per patient day shall be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. *Use of the pass-through and add-on.* As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on Form 470-4829, Nursing Facility Medicaid Enhanced Payment Report, demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference shall be used to increase compensation and costs of employment for direct care workers determined pursuant to 2009 Iowa Acts, Senate File 476.

(2) No less than 60 percent of the difference shall be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to 2009 Iowa Acts, Senate File 476.

d. *Effective date.* Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36, Division II, has been approved by the federal Centers for Medicare and Medicaid Services, none of the nursing facility rate-setting methodologies of this subrule shall become effective.

e. *End date.* If the federal Centers for Medicare and Medicaid Services determines that federal financial participation to match money collected from the quality assurance assessment pursuant to

441—Chapter 36, Division II, is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule shall be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department shall:

- (1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;
- (2) Recompute Medicaid payments due based on the recalculated Medicaid rates;
- (3) Recoup any previous overpayments; and
- (4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16, Iowa Code chapter 249K, and 2009 Iowa Code Supplement chapter 249L.

[ARC 8258B, IAB 11/4/09, effective 1/1/10; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8995B, IAB 8/11/10, effective 9/15/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1806C, IAB 1/7/15, effective 3/1/15]

#### **441—81.7(249A) Continued review.**

**81.7(1) Level of care.** The IME medical services unit shall review Medicaid members' need of continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1).

**81.7(2) PASRR.** As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

- a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);
- b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and
- c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.3(3)"b."

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.  
[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

#### **441—81.8(249A) Quality of care review.** Rescinded IAB 8/8/90, effective 10/1/90.

#### **441—81.9(249A) Records.**

**81.9(1) Content.** The facility shall as a minimum maintain the following records:

- a. All records required by the department of public health and the department of inspections and appeals.
- b. Records of all treatments, drugs, and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.
- c. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.
- d. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

*e.* All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

*f.* Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

*g.* Resident accounts.

*h.* In-service education program records.

*i.* Inspection reports pertaining to conformity with federal, state and local laws.

*j.* Residents' personal records.

*k.* Residents' medical records.

*l.* Disaster preparedness reports.

**81.9(2) Retention.** Records identified in subrule 81.9(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

**81.9(3) Change of owner.** All records shall be retained within the facility upon change of ownership. This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

#### **441—81.10(249A) Payment procedures.**

**81.10(1) Method of payment.** Except for Medicaid accountability measures payment established in paragraph 81.6(16) "g," facilities shall be reimbursed under a modified price-based vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—81.6(249A). Effective July 1, 2002, the per diem rate shall include an amount for Medicaid accountability measures.

**81.10(2) Authorization of payment.** The department shall authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

**81.10(3)** Rescinded IAB 8/9/89, effective 10/1/89.

**81.10(4) Periods authorized for payment.**

*a.* Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

*b.* Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

*c.* Payment will be approved for the day of admission but not the day of discharge or death.

*d.* Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

*e.* Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

*f.* Payment for periods when residents are absent for a visit, vacation, or hospitalization shall be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which shall be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care shall be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. In-state nursing facilities serving Medicaid eligible patients who require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care as determined by the peer review organization shall receive reimbursement for the care of these patients equal to the sum of the Medicare-certified hospital-based nursing facility direct care rate component limit plus the Medicare-certified hospital-based nursing facility non-direct care rate component limit factor pursuant to subparagraph 81.6(16)“f”(3). Facilities may continue to receive reimbursement at this rate for 30 days for any person weaned from a respirator who continues to reside in the facility and continues to meet skilled care criteria for those 30 days.

i. Payment for residents of a special population facility licensed by the department of inspections and appeals as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident’s guardian or legal representative, that Iowa Medicaid may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

- (1) The wrong surgical or other invasive procedure is performed on a resident; or
- (2) A surgical or other invasive procedure is performed on the wrong body part; or
- (3) A surgical or other invasive procedure is performed on the wrong resident.

**81.10(5) Supplementation.** Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the Iowa Medicaid program as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2)“a”(4), medical supplies except for those listed in 441—paragraph 78.10(4)“b,” oxygen except under circumstances specified in 441—paragraph 78.10(2)“a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician except for those specified in 441—paragraph 78.1(2)“f.”

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The Medicaid program will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

- (1) Physician services.
- (2) Ambulance services.
- (3) Hospital services.
- (4) Hearing aids, braces and prosthetic devices.
- (5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2) “a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

- (1) Drugs covered pursuant to 441—subrule 78.1(2).
- (2) Dental services.
- (3) Optician and optometrist services.
- (4) Repair of medical equipment and appliances that belong to the resident.
- (5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.
- (6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR § 483.10(c)(8)(ii).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident’s subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility’s occupancy rate was less than 50 percent as of the first day of the month or as of the resident’s subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private-pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall inform all residents, prospective residents, and their legal representatives of the following:

- That if the resident desires a private room, the resident or resident's family may provide supplementation by directly paying the facility the amount of supplementation;
- The nursing facility's policy if a resident residing in a private room converts from private pay to payment under the medical assistance program but the resident or resident's family is not willing or able to pay supplementation for the private room;
- The private rooms for which supplementation is available, including a description and identification of such rooms; and
- The process for an individual to take legal responsibility for providing supplementation, including identification of the individual and the extent of the legal responsibility.

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record all of the following:

- A description and identification of the private room for which the nursing facility is receiving supplementation;
- The identity of the individual making the supplemental payments;
- The private-pay charge for the private room for which the nursing facility is receiving supplementation; and
- The total charge to the resident for the private room for which the nursing facility is receiving supplementation, the portion of the total charge reimbursed under the medical assistance program, and the portion of the total charge reimbursed through supplementation.

8. Supplementation pursuant to this subparagraph shall not be required as a precondition of admission, expedited admission, or continued stay in a facility.

9. The nursing facility shall ensure that all appropriate care is provided to all residents notwithstanding the applicability or availability of supplementation.

10. A private room for which supplementation is required shall be retained for the resident consistent with bed-hold policies.

11. A nursing facility that utilizes the supplementation pursuant to this subparagraph during any calendar year shall report to the department annually by January 15 the following information for the preceding calendar year:

- The total number of nursing facility beds available at the nursing facility, the number of such beds available in private rooms, and the number of such beds available in other types of rooms.
- The average occupancy rate of the facility on a monthly basis.
- The total number of residents for whom supplementation was utilized.
- The average private pay charge for a private room in the nursing facility.
- For each resident for whom supplementation was utilized, the total charge to the resident for the private room, the portion of the total charge reimbursed under the Medicaid program, and the total charge reimbursed through supplementation.

*f.* Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

*g.* The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.10(4) "j" and shall not discharge a resident due to nonpayment for such days.

**81.10(6)** *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

**81.10(7)** *Comparative charges between private pay and Medicaid residents.* Rescinded IAB 2/6/02, effective 4/1/02.

This rule is intended to implement Iowa Code section 249A.4.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 8995B**, IAB 8/11/10, effective 9/15/10; **ARC 0714C**, IAB 5/1/13, effective 7/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14; **ARC 1806C**, IAB 1/7/15, effective 3/1/15]

#### **441—81.11(249A) Billing procedures.**

**81.11(1)** *Claims.* Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims must be submitted electronically through

Iowa Medicaid's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise. A request for an adjustment to a paid claim must be received by the Iowa Medicaid enterprise within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

**81.11(2)** Reserved.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."  
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

**441—81.12(249A) Closing of facility.** When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the local office of the department.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

**441—81.13(249A) Conditions of participation for nursing facilities.** All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

**81.13(1) Procedures for establishing health care facilities as Medicaid facilities.** All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "State Operations Manual."

*a.* The facility shall obtain the applicable license from the department of inspections and appeals and must be recommended for certification by the department of inspections and appeals.

*b.* The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

*c.* The Iowa Medicaid enterprise provider services unit shall transmit an application form and a copy of the nursing facility provider manual to the facility.

*d.* The facility shall complete its portion of the application form and submit it to the Iowa Medicaid enterprise provider services unit.

*e.* The Iowa Medicaid enterprise provider services unit shall review the application form and verify with the department of inspections and appeals that the facility is licensed and has been recommended for certification.

*f.* Prior to requesting enrollment, the facility shall contact the department of inspections and appeals to schedule a survey. The department of inspections and appeals shall schedule and complete a survey of the facility.

*g.* The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.

*h.* The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division department of inspections and appeals. This plan must be approved before the facility can be certified.

*i.* The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.

*j.* When certification is recommended, the department of inspections and appeals shall notify the department recommending a provider agreement.

*k.* Rescinded IAB 12/6/95, effective 2/1/96.

**81.13(2) Medicaid provider agreements.** The health care facility shall be recommended for certification by the department of inspections and appeals for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

*a.* Rescinded IAB 2/3/93, effective 4/1/93.

- b. Rescinded IAB 2/3/93, effective 4/1/93.
- c. Rescinded IAB 2/3/93, effective 4/1/93.
- d. Rescinded IAB 2/3/93, effective 4/1/93.
- e. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

f. Rescinded IAB 2/3/93, effective 4/1/93.

**81.13(3) *Distinct part requirement.*** All facilities which provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections and appeals.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work regularly therein. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident's medical chart and stands as a continuing order unless the circumstances requiring the exception change.

**81.13(4) *Civil rights.*** The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians' privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

**81.13(5) *Resident rights.*** The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident, including each of the following rights:

a. *Exercise of rights.*

(1) The resident has the right to exercise rights as a resident of the facility and as a citizen of the United States.

(2) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising those rights.

(3) In the case of a resident adjudged incompetent under the laws of a state, by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(4) In the case of a resident who has not been adjudged incompetent by the state court, any legal-surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

b. *Notice of rights and services.*

(1) The facility shall inform the resident, both orally and in writing in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility shall also provide the resident with

the pamphlet "Medicaid for People in Nursing Homes and Other Care Facilities," Comm. 52. This notification shall be made prior to or upon admission and during the resident's stay. Receipt of this information, and any amendments to it, must be acknowledged in writing.

(2) The resident or the resident's legal representative has the right, upon an oral or written request, to access all records pertaining to the resident including clinical records within 24 hours (excluding weekends and holidays); and after receipt of the records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the facility.

(3) The resident has the right to be fully informed in language that the resident can understand of the resident's total health status, including, but not limited to, medical condition.

(4) The resident has the right to refuse treatment and to refuse to participate in experimental research.

(5) The facility shall:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing facility services under the state plan and for which the resident may not be charged and of those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in number "1" of this subparagraph.

(6) The facility shall inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

(7) The facility shall furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds.

2. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's nonexempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in the resident's process of spending down to Medicaid eligibility levels.

3. A posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the state ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit.

4. A statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect and misappropriation of resident property in the facility.

(8) The facility shall inform each resident of the name, specialty and way of contacting the physician responsible for the resident's care.

(9) The facility shall prominently display in the facility written information and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by these benefits.

(10) Notification of changes.

1. A facility shall immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility.

2. The facility shall also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

3. The facility shall record and periodically update the address and telephone number of the resident's legal representative or interested family member.

*c. Protection of resident funds.*

(1) The resident has the right to manage the resident's financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(2) Management of personal funds. Upon written authorization of a resident, the facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified in subparagraphs (3) to (8) of this paragraph.

(3) Deposit of funds. The facility shall deposit any residents' personal funds in excess of \$50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share.

The facility shall maintain a resident's personal funds that do not exceed \$50 in a non-interest-bearing account, an interest-bearing account, or petty cash fund.

(4) Accounting and records. The facility shall establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system shall preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record shall be available through quarterly statements and on request to the resident or the resident's legal representative.

(5) Notice of certain balances. The facility shall notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person.

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(6) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

(7) Assurance of financial security. The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the department of inspections and appeals and the department of human services, to ensure the security of all personal funds of residents deposited with the facility.

(8) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

*d. Free choice.* The resident has the right to:

(1) Choose a personal attending physician.

(2) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

(3) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

*e. Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(2) Except as provided in subparagraph (3) below, the resident may approve or refuse the release of personal and clinical records to any person outside the facility.

(3) The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution or record release is required by law.

*f. Grievances.* A resident has the right to:

(1) Voice grievances without discrimination or reprisal for voicing the grievances. The grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.

(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

*g. Examination of survey results.* A resident has the right to:

(1) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination in a place readily accessible to residents, and must post a notice of their availability.

(2) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

*h. Work.* The resident has the right to:

(1) Refuse to perform services for the facility.

(2) Perform services for the facility if the resident chooses, when:

1. The facility has documented the need or desire for work in the plan of care.

2. The plan specifies the nature of the services performed and whether the services are voluntary or paid.

3. Compensation for paid services is at or above prevailing rates.

4. The resident agrees to the work arrangement described in the plan of care.

5. Rescinded IAB 3/4/92, effective 4/8/92.

*i. Mail.* The resident has the right to privacy in written communications, including the right to send and receive mail promptly that is unopened and to have access to stationery, postage and writing implements at the resident's own expense.

*j. Access and visitation rights.*

(1) The resident has the right and the facility shall provide immediate access to any resident by the following:

1. Any representative of the secretary of the Department of Health and Human Services.

2. Any representative of the state.

3. The resident's individual physician.

4. The state long-term care ombudsman.

5. The agency responsible for the protection and advocacy system for developmentally disabled individuals.

6. The agency responsible for the protection and advocacy system for mentally ill individuals.

7. Immediate family or other relatives of the resident subject to the resident's right to deny or withdraw consent at any time.

8. Others who are visiting with the consent of the resident subject to reasonable restrictions and to the resident's right to deny or withdraw consent at any time.

(2) The facility shall provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(3) The facility shall allow representatives of the state ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with state law.

*k. Telephone.* The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

*l. Personal property.* The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

*m. Married couples.* The resident has the right to share a room with the resident's spouse when married residents live in the same facility and both spouses consent to the arrangement.

*n. Self-administration of drugs.* An individual resident has the right to self-administer drugs if the interdisciplinary team has determined that this practice is safe.

*o. Refusal of certain transfers.*

(1) A person has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a skilled nursing facility from the distinct part of the institution that is a skilled nursing facility to a part of the institution that is not a skilled nursing facility or, if a resident of a nursing facility, from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a skilled nursing facility.

(2) A resident's exercise of the right to refuse transfer under subparagraph (1) does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

*p. Advance directives.*

(1) The nursing facility, at the time of admission, shall provide written information to each resident which explains the resident's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives and the nursing facility's policies regarding the implementation of these rights.

(2) The nursing facility shall document in the resident's medical record whether or not the resident has executed an advance directive.

(3) The nursing facility shall not condition the provision of care or otherwise discriminate against a resident based on whether or not the resident has executed an advance directive.

(4) The nursing facility shall ensure compliance with requirements of state law regarding advance directives.

(5) The nursing facility shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this paragraph shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any nursing facility which as a matter of conscience cannot implement an advance directive.

**81.13(6)** *Admission, transfer and discharge rights.*

*a. Transfer and discharge.*

(1) Definition: Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3. The safety of persons in the facility is endangered.

4. The health of persons in the facility would otherwise be endangered.

5. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid.

6. The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in subparagraph (2), numbers 1 through 5 above, the resident's clinical record shall be documented. The documentation shall be made by:

1. The resident's physician when transfer or discharge is necessary under subparagraph (2), number 1 or 2.

2. A physician when transfer or discharge is necessary under subparagraph (2), number 4.

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. Record the reasons in the resident's clinical record.

3. Include in the notice the items in subparagraph (6) below.

(5) Timing of the notice. The notice of transfer or discharge shall be made by the facility at least 30 days before the resident is transferred or discharged except that notice shall be made as soon as practicable before transfer or discharge when:

1. The safety of persons in the facility would be endangered.

2. The health of persons in the facility would be endangered.

3. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

4. An immediate transfer or discharge is required by the resident's urgent medical needs.

5. A resident has not resided in the facility for 30 days.

(6) Contents of the notice. The written notice shall include the following:

1. The reason for transfer or discharge.

2. The effective date of transfer or discharge.

3. The location to which the resident is transferred or discharged.

4. A statement that the resident has the right to appeal the action to the department.

5. The name, address, and telephone number of the state long-term care ombudsman.

6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals for residents with developmental disabilities.

7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals for residents who are mentally ill.

(7) Orientation for transfer or discharge. A facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

*b. Notice of bed-hold policy and readmission.*

(1) Notice before transfer. Before a facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the facility shall provide written information to the resident and a family member or legal representative that specifies:

1. The duration of the bed-hold policy under the state plan during which the resident is permitted to return and resume residence in the facility.

2. The facility's policies regarding bed-hold periods, which shall be consistent with subparagraph (3) below, permitting a resident to return.

(2) Notice upon transfer. At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility shall provide written notice to the resident and a family member or legal representative, which specifies the duration of the bed-hold policy described in subparagraph (1) above.

(3) Permitting resident to return to facility. A nursing facility shall establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, is readmitted to the facility immediately upon the first availability of a bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

*c. Equal access to quality care.*

(1) A facility shall establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all persons regardless of source of payment.

(2) The facility may charge any amount for services furnished to non-Medicaid residents consistent with the notice requirement in 81.13(1)"a"(5).

(3) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

*d. Admissions policy.*

(1) The facility shall not require residents or potential residents to:

1. Waive their rights to Medicare or Medicaid; or

2. Give oral or written assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits. However, a continuing care retirement community or a life care community that is licensed, registered, certified, or the equivalent by the state, including a nursing facility that is part of such a community, may require in its contract for admission that before a resident applies for medical assistance, the resources that the resident declared for the purposes of admission must be spent on the resident's care, subject to 441—subrule 75.5(3), 441—paragraph 75.5(4)“a,” and 441—subrule 75.16(2).

(2) The facility shall not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may require a person who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(3) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However:

1. A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term “nursing facility services” so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of these additional services.

2. A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

(4) States or political subdivisions may apply stricter admission standards under state or local laws than are specified in these rules, to prohibit discrimination against persons entitled to Medicaid.

**81.13(7) Resident behavior and facility practices.**

*a. Restraints.* The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

*b. Abuse.* The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

*c. Staff treatment of residents.* The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

\* (1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

\*See Objection filed 8/25/92 published herein at end of 441—Chapter 81.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections and appeals) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of

inspections and appeals) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

**81.13(8) *Quality of life.*** A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

*a. Dignity.* The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of the resident's individuality.

*b. Self-determination and participation.* The resident has the right to:

(1) Choose activities, schedules, and health care consistent with the resident's interests, assessments and plans of care.

(2) Interact with members of the community both inside and outside the facility.

(3) Make choices about aspects of life in the facility that are significant to the resident.

*c. Participation in resident and family groups.*

(1) A resident has the right to organize and participate in resident groups in the facility.

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

(3) The facility shall provide a resident or family group, if one exists, with private space.

(4) Staff or visitors may attend meetings at the group's invitation.

(5) The facility shall provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

(6) When a resident or family group exists, the facility shall listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

*d. Participation in other activities.* A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

*e. Accommodation of needs.* A resident has the right to:

(1) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

(2) Receive notice before the resident's room or roommate in the facility is changed.

*f. Activities.*

(1) The facility shall provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

(2) The activities program shall be directed by a qualified professional who meets one of the following criteria:

1. Is a qualified therapeutic recreation specialist or an activities professional who is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.

2. Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting.

3. Is a qualified occupational therapist or occupational therapy assistant.

4. Has completed a training course approved by the state.

*g. Social services.*

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis.

(3) Qualifications of social worker. A qualified social worker is a person who meets both of the following criteria:

1. A bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation, counseling and psychology.

2. One year of supervised social work experience in a health care setting working directly with individuals.

*h. Environment.* The facility shall provide:

(1) A safe, clean, comfortable and homelike environment, allowing the resident to use personal belongings to the extent possible.

(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

(3) Clean bed and bath linens that are in good condition.

(4) Private closet space in each resident room.

(5) Adequate and comfortable lighting levels in all areas.

(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, shall maintain a temperature range of 71 to 81 degrees Fahrenheit.

(7) For the maintenance of comfortable sound levels.

**81.13(9) Resident assessment.** The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability.

*a. Admission orders.* At the time each resident is admitted, the facility shall have physician orders for the resident's immediate care.

*b. Comprehensive assessments.*

(1) The facility shall make a comprehensive assessment of a resident's needs which is based on the minimum data set (MDS) specified by the department of inspections and appeals, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2) The assessment process shall include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. The comprehensive assessment shall include at least the following information:

1. Identification and demographic information.

2. Customary routine.

3. Cognitive patterns.

4. Communication.

5. Vision.

6. Mood and behavior patterns.

7. Psychosocial well-being.

8. Physical functioning and structural problems.

9. Continence.

10. Disease diagnoses and health conditions.

11. Dental and nutritional status.

12. Skin condition.

13. Activity pursuit.

14. Medications.

15. Special treatments and procedures.

16. Discharge potential.

17. Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

18. Documentation of participation in assessment.

19. Additional specification relating to resident status as required in Section S of the MDS.

(3) Frequency. Assessments shall be conducted:

1. Within 14 calendar days after admission or readmission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. "Readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.

2. Within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. A "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has

an impact on more than one area of the resident's health status, and that requires either interdisciplinary review, revision of the care plan, or both.

3. In no case less often than once every 12 months.

(4) Review of assessments. The facility shall examine each resident no less than once every three months, and as appropriate, revise the resident's assessment to ensure the continued accuracy of the assessment.

(5) Maintenance and use. A facility shall maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results to develop, review and revise the resident's comprehensive plan of care.

(6) Coordination. The facility shall coordinate assessments with any state-required preadmission screening program to the maximum extent practicable to avoid duplicative testing and effort.

(7) Automated data processing requirement.

1. Entering data. Within seven days after a facility completes a resident's assessment, a facility shall enter the following information for the resident into a computerized format that meets the specifications defined in numbered paragraphs "2" and "4" below.

- Admission assessment.
- Annual assessment updates.
- Significant change in status assessments.
- Quarterly review assessments.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, if there is no admission assessment.

2. Transmitting data. Within seven days after a facility completes a resident's assessment, a facility shall be capable of transmitting to the state each resident's assessment information contained in the MDS in a format that conforms to standard record layouts and data dictionaries and that passes edits that ensure accurate and consistent coding of the MDS data as defined by the Centers for Medicare and Medicaid Services (CMS) and the department of human services or the department of inspections and appeals.

3. Monthly transmittal requirements. On at least a monthly basis, a facility shall input and electronically transmit accurate and complete MDS data for all assessments conducted during the previous month, including the following:

- Admission assessment.
- Annual assessment.
- Significant correction of prior full assessment.
- Significant correction of prior quarterly assessment.
- Quarterly review.
- A subset of items upon a resident's transfer, reentry, discharge, and death.
- Background (face sheet) information, for an initial transmission of MDS data on a resident who does not have an admission assessment.

4. The facility must transmit MDS data in the ASCII format specified by CMS.

(8) Resident-identifiable information. A facility shall not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

*c. Accuracy of assessments.* The assessment shall accurately reflect the resident's status.

(1) Coordination. Each assessment shall be conducted or coordinated with the appropriate participation of health professionals. Each assessment shall be conducted or coordinated by a registered nurse.

(2) Certification. Each person who completes a portion of the assessment shall sign and certify the accuracy of that portion of the assessment. A registered nurse shall sign and certify that the assessment is completed.

(3) Penalty for falsification. An individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment. An individual who willfully and knowingly causes another individual to certify a

material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

(4) Use of independent assessors. If the department of human services or the department of inspections and appeals determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under subparagraph (3) above, the department of human services or the department of inspections and appeals may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department of human services or the department of inspections and appeals for a period specified by the agency.

*d. Comprehensive care plans.*

(1) The facility shall develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan shall describe the following:

1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under subrule 81.13(10).

2. Any services that would otherwise be required under subrule 81.13(10), but are not provided due to the resident's exercise of rights under subrule 81.13(5), including the right to refuse treatment under subrule 81.13(5), paragraph "b," subparagraph (4).

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

(3) The services provided or arranged by the facility shall meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care.

*e. Discharge summary.* When the facility anticipates discharges, a resident shall have a discharge summary that includes:

(1) A recapitulation of the resident's stay.

(2) A final summary of the resident's status to include items in paragraph "b," subparagraph (2) above, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.

(3) A postdischarge plan of care developed with the participation of the resident and resident's family which will assist the resident to adjust to a new living environment.

*f. Preadmission screening for mentally ill individuals and individuals with mental retardation.* Rescinded IAB 9/7/11, effective 9/1/11.

*g. Preadmission resident assessment.* The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

**81.13(10) Quality of care.** Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

*a. Activities of daily living.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress and groom; transfer and ambulate; toilet; eat, and to use speech, language or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve the resident's abilities specified in subparagraph (1) above.

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

*b. Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility shall, if necessary, assist the resident:

(1) In making appointments.

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

*c. Pressure sores.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable.

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

*d. Urinary incontinence.* Based on the resident's comprehensive assessment, the facility shall ensure that:

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

*e. Range of motion.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion to prevent further decrease in range of motion.

*f. Mental and psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction or increased withdrawn, angry or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

*g. Naso-gastric tubes.* Based on the comprehensive assessment of a resident, the facility shall ensure that:

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable.

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers and to restore, if possible, normal eating skills.

*h. Accidents.* The facility shall ensure that:

(1) The resident environment remains as free of accident hazards as is possible.

(2) Each resident receives adequate supervision and assistive devices to prevent accidents.

*i. Nutrition.* Based on a resident's comprehensive assessment, the facility shall ensure that a resident:

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

(2) Receives a therapeutic diet when there is a nutritional problem.

*j. Hydration.* The facility shall provide each resident with sufficient fluid intake to maintain proper hydration and health.

*k. Special needs.* The facility shall ensure that residents receive proper treatment and care for the following special services:

- (1) Injections.
- (2) Parenteral and enteral fluids.
- (3) Colostomy, ureterostomy or ileostomy care.
- (4) Tracheostomy care.
- (5) Tracheal suctioning.
- (6) Respiratory care.
- (7) Foot care.
- (8) Prostheses.

*l. Unnecessary drugs.*

(1) General. Each resident's drug regimen shall be free from unnecessary drugs. An unnecessary drug is any drug when used:

1. In excessive dose including duplicate drug therapy; or
2. For excessive duration; or
3. Without adequate monitoring; or
4. Without adequate indications for its use; or
5. In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
6. Any combinations of the reasons above.

(2) Antipsychotic drugs. Based on a comprehensive assessment of a resident, the facility shall ensure that:

1. Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record.
2. Residents who use antipsychotic drugs receive gradual dose reductions and behavioral programming, unless clinically contraindicated in an effort to discontinue these drugs.

*m. Medication errors.* The facility shall ensure that:

- (1) It is free of significant medication error rates of 5 percent or greater.
- (2) Residents are free of any significant medication errors.

**81.13(11) Nursing services.** The facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

*a. Sufficient staff.*

(1) The facility shall provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1. Except when waived under paragraph "c," licensed nurses.
2. Other nursing personnel.

(2) Except when waived under paragraph "c," the facility shall designate a licensed nurse to serve as a charge nurse on each tour of duty.

*b. Registered nurse.*

(1) Except when waived under paragraph "c," the facility shall use the services of a registered nurse for at least eight consecutive hours a day, seven days a week.

(2) Except when waived under paragraph "c," the facility shall designate a registered nurse to serve as the director of nursing on a full-time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

*c. Nursing facilities.* Waiver of requirement to provide licensed nurses on a 24-hour basis. A facility may request a waiver from either the requirement that a nursing facility provide a registered nurse for at least eight consecutive hours a day, seven days a week, as specified in paragraph "b," or the

requirement that a nursing facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in paragraph “a,” if the following conditions are met:

(1) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(2) The department of inspections and appeals determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(3) The department of inspections and appeals finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(4) A waiver granted under the conditions listed in paragraph “c” is subject to annual department of inspections and appeals review.

(5) In granting or renewing a waiver, a facility may be required by the department of inspections and appeals to use other qualified, licensed personnel.

(6) The department of inspections and appeals shall provide notice of a waiver granted under this paragraph to the state long-term care ombudsman established under Section 307(a)(12) of the Older Americans Act of 1965 and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(7) The nursing facility that is granted a waiver under this paragraph shall notify residents of the facility or, where appropriate, the guardians or legal representatives of the residents and members of their immediate families of the waiver.

**81.13(12) Dietary services.** The facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

*a. Staffing.* The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is licensed by the state according to Iowa Code chapter 152A.

*b. Sufficient staff.* The facility shall employ sufficient support personnel competent to carry out the functions of the dietary service.

*c. Menus and nutritional adequacy.* Menus shall:

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(2) Be prepared in advance.

(3) Be followed.

*d. Food.* Each resident receives and the facility provides:

(1) Food prepared by methods that conserve nutritive value, flavor and appearances.

(2) Food that is palatable, attractive and at the proper temperature.

(3) Food prepared in a form designed to meet individual needs.

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

*e. Therapeutic diets.* Therapeutic diets shall be prescribed by the attending physician.

*f. Frequency of meals.*

(1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There shall be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in subparagraph (4) below.

(3) The facility shall offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

*g. Assistive devices.* The facility shall provide special eating equipment and utensils for residents who need them.

*h. Sanitary conditions.* The facility shall:

(1) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(2) Store, prepare, distribute and serve food under sanitary conditions.

(3) Dispose of garbage and refuse properly.

**81.13(13) Physician services.** A physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

*a. Physician supervision.* The facility shall ensure that:

(1) The medical care of each resident is supervised by a physician.

(2) Another physician supervises the medical care of residents when their attending physician is unavailable.

*b. Physician visits.* The physician shall:

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph "c" below.

(2) Write, sign and date progress notes at each visit.

(3) Sign and date all orders.

*c. Frequency of physician visits.*

(1) The resident shall be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(3) Except as provided in paragraph "e," all required physician visits shall be made by the physician personally.

*d. Availability of physicians for emergency care.* The facility shall provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

*e. Performance of physician tasks in nursing facilities.* Any required physician task in a nursing facility (including tasks which the rules specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility, but who is working in collaboration with a physician except where prohibited by state law.

**81.13(14) Specialized services.** When indicated, specialized services shall be provided to residents as follows:

*a. Specialized rehabilitative services.* Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, and occupational therapy, are required in the resident's comprehensive plan of care, the facility shall:

(1) Provide the required services; or

(2) Obtain the required services from an outside provider of specialized rehabilitative services.

*b. Specialized services for mental illness.* "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) May be provided only by a specialized licensed or certified practitioner;

(5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and

(6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service which is available through the Iowa plan for behavioral health and for which the member meets eligibility criteria.

*c. Specialized services for intellectual disability.* “Specialized services for intellectual disability” means services that:

(1) Are beyond the normal scope and intensity of nursing facility responsibility;

(2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

(3) Are provided through a professionally developed plan of care with specific goals and interventions;

(4) Must be supervised by a qualified intellectual disability professional; and

(5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

**81.13(15) Dental services.** The facility shall assist residents in obtaining routine and 24-hour emergency dental care. The facility shall:

*a.* Provide or obtain from an outside resource the following dental services to meet the needs of each resident:

(1) Routine dental services to the extent covered under the state plan.

(2) Emergency dental services.

*b.* If necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist’s office.

*c.* Promptly refer residents with lost or damaged dentures to a dentist.

**81.13(16) Pharmacy services.** The facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

*a. Procedures.* A facility shall provide pharmaceutical services (including procedures that ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

*b. Service consultation.* The facility shall employ or obtain the services of a licensed pharmacist who:

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

*c. Drug regimen review.*

(1) The drug regimen of each resident shall be reviewed at least once a month by a licensed pharmacist.

(2) The pharmacist shall report any irregularities to the attending physician and the director of nursing, and these reports shall be acted upon.

*d. Labeling of drugs and biologicals.* Drugs and biologicals used in the facility shall be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

*e. Storage of drugs and biologicals.*

(1) In accordance with state and federal laws, the facility shall store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

(2) The facility shall provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

*f. Consultant pharmacists.* When the facility does not employ a licensed pharmacist, it shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration and disposal and record keeping of drugs and biologicals. The formal arrangements with the licensed pharmacist shall include separate written contracts for pharmaceutical vendor services and consultant pharmacist services. The consultant's visits are scheduled to be of sufficient duration and at a time convenient to work with nursing staff on the resident care plan, consult with the administrator and others on developing and implementing policies and procedures, and planning in-service training and staff development for employees. The consultant shall provide monthly drug regimen review reports. The facility shall provide reimbursement for consultant pharmacists based on fair market value. Documentation of consultation shall be available for review in the facility.

**81.13(17) Infection control.** The facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

*a. Infection control program.* The facility shall establish an infection control program under which it:

- (1) Investigates, controls and prevents infections in the facility.
- (2) Decides what procedures, such as isolation, should be applied to an individual resident.
- (3) Maintains a record of incidents and corrective actions related to infections.

*b. Preventing spread of infection.*

(1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility shall isolate the resident.

(2) The facility shall prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility shall require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

*c. Linens.* Personnel shall handle, store, process, and transport linens so as to prevent the spread of infection.

**81.13(18) Physical environment.** The facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

*a. Life safety from fire.* Except as provided in subparagraph (1) or (3) below, the facility shall meet the applicable provisions of the 1985 edition of the Life Safety Code of the National Fire Protection Association.

(1) A facility is considered to be in compliance with this requirement as long as the facility:

1. On November 26, 1982, complied with or without waivers with the requirements of the 1967 or 1973 editions of the Life Safety Code and continues to remain in compliance with those editions of the code; or

2. On May 9, 1988, complied, with or without waivers, with the 1981 edition of the Life Safety Code and continues to remain in compliance with that edition of the Code.

(2) When Medicaid nursing facilities and Medicaid distinct part nursing facility providers request a waiver of Life Safety Code requirements in accordance with Subsection 1919(d)(2)(B)(i) of the Social Security Act, the department of inspections and appeals shall forward the requests to the Centers for Medicare and Medicaid Services Regional Office for review and approval.

(3) The provisions of the Life Safety Code do not apply in a state where the Centers for Medicare and Medicaid Services finds that a fire and safety code imposed by state law adequately protects patients, residents and personnel in long-term care facilities.

*b. Emergency power.*

(1) An emergency electrical power system shall supply power adequate at least for lighting all entrances and exits, equipment to maintain the fire detection, alarm and extinguishing systems, and life support systems in the event the normal electrical supply is interrupted.

(2) When life support systems are used that have no nonelectrical backup, the facility shall provide emergency electrical power with an emergency generator, as defined in NFPA 99, Health Care Facilities, that is located on the premises.

*c. Space and equipment.* The facility shall:

(1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care.

(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

*d. Resident rooms.* Resident rooms shall be designed and equipped for adequate nursing care, comfort and privacy of residents.

(1) Bedrooms shall:

1. Accommodate no more than four residents.

2. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

3. Have direct access to an exit corridor.

4. Be designed or equipped to ensure full visual privacy for each resident.

5. In facilities initially certified after March 31, 1992, except in private rooms, each bed shall have ceiling-suspended curtains, which extend around the bed to provide total visual privacy, in combination with adjacent walls and curtains.

6. Have at least one window to the outside.

7. Have a floor at or above grade level.

(2) The facility shall provide each resident with:

1. A separate bed of proper size and height for the convenience of the resident.

2. A clean, comfortable mattress.

3. Bedding appropriate to the weather and climate.

4. Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.

(3) The department of inspections and appeals may permit variations in requirements specified in paragraph "d," subparagraph (1), numbers 1 and 2 above relating to rooms in individual cases when the facility demonstrates in writing that the variations are required by the special needs of the residents and will not adversely affect residents' health and safety.

*e. Toilet facilities.* Each resident room shall be equipped with or located adjacent to toilet facilities unless a waiver is granted by the department of inspections and appeals. Additionally, each resident room shall be equipped with or located adjacent to bathing facilities.

*f. Resident call system.* The nurse's station shall be equipped to receive resident calls through a communication system from:

(1) Resident rooms.

(2) Toilet and bathing facilities.

*g. Dining and resident activities.* The facility shall provide one or more rooms designated for resident dining and activities. These rooms shall:

(1) Be well lighted.

(2) Be well ventilated, with nonsmoking areas identified.

(3) Be adequately furnished.

(4) Have sufficient space to accommodate all activities.

*h. Other environmental conditions.* The facility shall provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. The facility shall:

- (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.
- (2) Have adequate outside ventilation by means of windows or mechanical ventilation or a combination of the two.
- (3) Equip corridors with firmly secured handrails on each side.
- (4) Maintain an effective pest control program so that the facility is free of pests and rodents.

**81.13(19) Administration.** A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

*a. Licensure.* A facility shall be licensed under applicable state and federal law.

*b. Compliance with federal, state and local laws and professional standards.* The facility shall operate and provide services in compliance with all applicable federal, state, and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

*c. Relationship to other Department of Health and Human Services (HHS) regulations.* In addition to compliance with these rules, facilities shall meet the applicable provisions of other HHS regulations, including, but not limited to, those pertaining to nondiscrimination on the basis of race, color, or national origin, nondiscrimination on the basis of handicap, nondiscrimination on the basis of age, protection of human subjects of research, and fraud and abuse. Although these regulations are not in themselves considered requirements under these rules, their violation may result in the termination or suspension of, or the refusal to grant or continue payment with federal funds.

*d. Governing body.*

(1) The facility shall have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(2) The governing body appoints the administrator who is:

1. Licensed by the state.
2. Responsible for management of the facility.

*e. Required training of nurse aides.*

(1) Definitions.

“Licensed health professional” means a physician; physician assistant; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

“Nurse aide” means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis, unless:

1. That person is competent to provide nursing and nursing-related services.
2. That person has completed a training and competency evaluation program or a competency evaluation program approved by the department of inspections and appeals; or that person has been deemed or determined competent by the department of inspections and appeals.

(3) Nonpermanent employees. A facility shall not use on a temporary, per diem, leased, or any basis other than a permanent employee any person who does not meet the requirements in subparagraph (2).

(4) Competency. A facility shall not use any person who has worked less than four months as a nurse aide in that facility unless the person:

1. Is a permanent employee and is in a nurse aide training and competency evaluation program approved by the department of inspections and appeals;

2. Has demonstrated competence through satisfactory participation in a nurse aide training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals; or

3. Has been deemed or determined competent by the department of inspections and appeals.

(5) Registry verification. Before allowing a person to serve as a nurse aide, a facility shall receive registry verification that the person has met competency evaluation requirements unless:

1. The person is a permanent employee and is in a training and competency evaluation program approved by the department of inspections and appeals; or

2. The person can prove that the person has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the department of inspections and appeals and has not yet been included in the registry. Facilities shall follow up to ensure that such a person actually becomes registered.

(6) Multistate registry verification. Before allowing a person to serve as a nurse aide, a facility shall seek information from every state registry the facility believes will include information on the person.

(7) Required retraining. If since October 1, 1990, there has been a continuous period of 24 consecutive months during none of which the person provided nursing or nursing-related services for monetary compensation, the person shall complete a new training and competency evaluation program or a new competency evaluation program.

(8) Regular in-service education. The facility shall complete a performance review of every nurse aide at least once every 12 months and shall provide regular in-service education based on the outcome of these reviews. The in-service training shall:

1. Be sufficient to ensure the continuing competencies of nurse aides, but shall be no less than 12 hours per year.

2. Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

3. For nurse aides providing services to persons with cognitive impairments, also address the care of the cognitively impaired.

*f. Proficiency of nurse aides.* The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

*g. Staff qualifications.*

(1) The facility shall employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these conditions of participation.

(2) Professional staff shall be licensed, certified or registered in accordance with applicable state laws.

*h. Use of outside resources.*

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in subparagraph (2) below.

(2) Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility and for the timeliness of the services.

*i. Medical director.*

(1) The facility shall designate a physician to serve as medical director.

(2) The medical director is responsible for implementation of resident care policies and the coordination of medical care in the facility.

*j. Laboratory services.*

(1) The facility shall provide or obtain clinical laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of the services furnished by laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

2. If the facility provides blood bank and transfusion services, it shall meet the requirements for laboratories specified in 42 CFR Part 493 as amended to October 1, 1990.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved or licensed to test specimens in the appropriate specialties or subspecialties of service in accordance with 42 CFR Part 493 as amended to October 1, 1990.

4. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services only from a laboratory that meets the requirements of 42 CFR Part 493 as amended to October 1, 1990, or from a physician's office.

(2) The facility shall:

1. Provide or obtain laboratory services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of clinical laboratory services.

*k. Radiology and other diagnostic services.*

(1) The facility shall provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

1. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation for hospitals.

2. If the facility does not provide its own diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(2) The facility shall:

1. Provide or obtain radiology and other diagnostic services only when ordered by the attending physician.

2. Promptly notify the attending physician of the findings.

3. Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

4. File in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

*l. Clinical records.*

(1) The facility shall maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

(2) Clinical records shall be retained for:

1. The period of time required by state law.

2. Five years from the date of discharge when there is no requirement in state law.

3. For a minor, three years after a resident reaches legal age under state law.

(3) The facility shall safeguard clinical record information against loss, destruction, or unauthorized use.

(4) The facility shall keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by:

1. Transfer to another health care institution.

2. Law.

3. Third-party payment contract.

4. The resident.

(5) The clinical record shall contain:

1. Sufficient information to identify the resident.

2. A record of the resident's assessments.

3. The plan of care and services provided.

4. The results of any preadmission screening conducted by the state.
5. Progress notes.
- m. Disaster and emergency preparedness.*
  - (1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.
  - (2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.
- n. Transfer agreement.*
  - (1) The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably ensures that:
    1. Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician.
    2. Medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether the residents can be adequately cared for in a less expensive setting than either the facility or the hospital, will be exchanged between the institutions.
  - (2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.
- o. Quality assessment and assurance.*
  - (1) A facility shall maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility's staff.
  - (2) The quality assessment and assurance committee:
    1. Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary.
    2. Develops and implements appropriate plans of action to correct identified quality deficiencies.
  - (3) The state or the Secretary of the Department of Health and Human Services may not require disclosure of the records of the committee except insofar as the disclosure is related to the compliance of the committee with the requirements of this paragraph.
  - (4) Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
- p. Disclosure of ownership.*
  - (1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104.
  - (2) The facility shall provide written notice to the department of inspections and appeals at the time of change, if a change occurs in:
    1. Persons with an ownership or control interest.
    2. The officers, directors, agents, or managing employees.
    3. The corporation, association, or other company responsible for the management of the facility.
    4. The facility's administrator or director of nursing.
  - (3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "a," and 249A.4.  
[ARC 8445B, IAB 1/13/10, effective 12/11/09; ARC 9726B, IAB 9/7/11, effective 9/1/11; ARC 9888B, IAB 11/30/11, effective 1/4/12; ARC 1806C, IAB 1/7/15, effective 3/1/15]

#### **441—81.14(249A) Audits.**

**81.14(1)** *Audit of financial and statistical report.* Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper

according to the rules set forth in 441—81.6(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

*a.* When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the health facility shall be suspended and eventually canceled from the nursing facility program, or

*b.* When a health facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

**81.14(2)** *Audit of proper billing and handling of patient funds.*

*a.* Field auditors of the department of inspections and appeals, or representatives of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

*b.* Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

*c.* The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

*d.* The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

*e.* When the facility fails to comply with paragraph “d,” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

*f.* When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a” and 249A.4.

**441—81.15(249A) Nurse aide training and testing programs.** Rescinded IAB 12/9/92, effective 2/1/93.

**441—81.16(249A) Nurse aide requirements and training and testing programs.**

**81.16(1)** *Deemed meeting of requirements.* A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the department of inspections and appeals if the nurse aide successfully completed a training and competency evaluation program before July 1, 1989. The aide would have satisfied this requirement if:

*a.* At least 60 hours were substituted for 75 hours; and

*b.* The aide has made up at least the difference in the number of hours in the program the aide completed and 75 hours in supervised practical nurse aide training or in regular in-service nurse education; or

c. The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 hours' duration; or

d. The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989; or

e. The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections and appeals determines would have met the requirements for approval at the time it was offered.

**81.16(2)** *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections and appeals shall, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of 81.13(19) "e" and 81.16(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections and appeals approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of 81.16(3).

2. A nurse aide competency evaluation program meets the requirements of 81.16(4).

(2) Except as provided by paragraph 81.16(2) "f," the department of inspections and appeals shall not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility which, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment under subrule 81.40(1) or 81.40(2).

(3) Rescinded IAB 10/7/98, effective 12/1/98.

c. Application process. Applications shall be submitted to the department of inspections and appeals before a new program begins and every two years thereafter on Form 427-0517, Application for Nurse Aide Training. The department of inspections and appeals shall, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections and appeals shall not grant approval of a nurse aide training and competency evaluation program for a period longer than two years. A program shall notify the department of inspections and appeals and the department of inspections and appeals shall review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval.

(1) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program offered by or in a facility described in 81.16(2) "b"(2).

(2) The department of inspections and appeals may withdraw approval of a nurse aide training and competency evaluation program or nurse aide competency evaluation program if the department of inspections and appeals determines that any of the applicable requirements for approval or registry, as set out in subrule 81.16(3) or 81.16(4), are not met.

(3) The department of inspections and appeals shall withdraw approval of a nurse aide training and competency evaluation program or a nurse aide competency evaluation program if the entity providing the program refuses to permit unannounced visits by the department of inspections and appeals.

(4) If the department of inspections and appeals withdraws approval of a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections and appeals shall notify the program in writing, indicating the reasons for withdrawal of approval of the program. Students who have started a training and competency evaluation program from which approval has been withdrawn shall be allowed to complete the course.

*f.* An exception to subparagraph 81.16(2)“*b*”(2) may be granted by the department of inspections and appeals (DIA) for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted Form 470-3494, Nurse Aide Education Program Waiver Request, to the DIA to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved nurse aide training and competency evaluation program (NATCEP).

(3) No other NATCEP program is offered within 30 minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by DIA.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the DIA indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the DIA to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP which shall return the evaluations to DIA.

**81.16(3)** *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections and appeals to approve required nurse aide training and testing programs. Policies and procedures governing approval of the programs are set forth in these rules.

*a.* For a nurse aide training and competency evaluation program to be approved by the department of inspections and appeals, it shall, at a minimum:

(1) Consist of no less than 75 clock hours of training.

(2) Include at least the subjects specified in 81.16(3).

(3) Include at least 15 hours of laboratory experience, 30 hours of classroom instruction (the first 16 hours of which must occur before the nurse aide has resident contact) and 30 hours of supervised clinical training. Supervised clinical training means training in a setting in which the trainee demonstrates knowledge while performing tasks on a resident under the general supervision of a registered nurse or licensed practical nurse.

(4) Ensure that students do not independently perform any services for which they have not been trained and found proficient by the instructor. It shall also ensure that students who are providing services to residents are under the general supervision of a licensed nurse or a registered nurse.

(5) Meet the following requirements for instructors who train nurse aides:

1. The training of nurse aides shall be performed by or under the general supervision of a registered nurse who possesses a minimum of two years of nursing experience, at least one year of which shall be in the provision of long-term care facility services.

2. Instructors shall be registered nurses and shall have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

3. In a facility-based program, when the director of nursing is a registered nurse, the training of nurse aides may be performed under the general supervision of the director of nursing for the facility. The director of nursing is prohibited from performing the actual training.

4. Other personnel from the health professions may supplement the instructor. Supplemental personnel shall have at least one year of experience in their fields.

5. The ratio of qualified trainers to students shall not exceed one instructor for every ten students in the clinical setting.

(6) Contain information regarding competency evaluation through written or oral and skills testing.

b. The curriculum of the nurse aide training program shall include:

(1) At least a total of 16 hours of training in the following areas prior to any direct contact with a resident:

1. Communication and interpersonal skills.
2. Infection control.
3. Safety and emergency procedures including the Heimlich maneuver.
4. Promoting residents' independence.
5. Respecting residents' rights.

(2) Basic nursing skills:

1. Taking and recording vital signs.
2. Measuring and recording height and weight.
3. Caring for the residents' environment.
4. Recognizing abnormal changes in body functioning and the importance of reporting these changes to a supervisor.

5. Caring for residents when death is imminent.

(3) Personal care skills, including, but not limited to:

1. Bathing.
2. Grooming, including mouth care.
3. Dressing.
4. Toileting.
5. Assisting with eating and hydration.
6. Proper feeding techniques.
7. Skin care.
8. Transfers, positioning, and turning.

(4) Mental health and social service needs:

1. Modifying aide's behavior in response to residents' behavior.
2. Awareness of developmental tasks associated with the aging process.
3. How to respond to resident behavior.
4. Allowing the resident to make personal choices, providing and reinforcing other behavior consistent with the resident's dignity.

5. Using the resident's family as a source of emotional support.

(5) Care of cognitively impaired residents:

1. Techniques for addressing the unique needs and behaviors of persons with dementia (Alzheimer's and others).

2. Communicating with cognitively impaired residents.
3. Understanding the behavior of cognitively impaired residents.
4. Appropriate responses to the behavior of cognitively impaired residents.
5. Methods of reducing the effects of cognitive impairments.

(6) Basic restorative services:

1. Training the resident in self-care according to the resident's ability.
2. Use of assistive devices in transferring, ambulation, eating and dressing.
3. Maintenance of range of motion.
4. Proper turning and positioning in bed and chair.
5. Bowel and bladder training.

6. Care and use of prosthetic and orthotic devices.
  - (7) Residents' rights:
    1. Providing privacy and maintenance of confidentiality.
    2. Promoting the residents' rights to make personal choices to accommodate their needs.
    3. Giving assistance in resolving grievances and disputes.
    4. Providing needed assistance in getting to and participating in resident and family groups and other activities.
    5. Maintaining care and security of residents' personal possessions.
    6. Promoting the residents' rights to be free from abuse, mistreatment, and neglect and the need to report any instances of this type of treatment to appropriate facility staff.
    7. Avoiding the need for restraints in accordance with current professional standards.
  - c. Prohibition of charges.
    - (1) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program or competency evaluation program may be charged for any portion of the program including any fees for textbooks or other required evaluation or course materials.
    - (2) If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility not later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:
      1. Add all costs incurred by the aides for the course, books, and tests.
      2. Divide the total arrived at in No. 1 above by 12 to prorate the costs over a one-year period and establish a monthly rate.
      3. The aide shall be reimbursed the monthly rate each month the aide works at the facility until one year from the time the aide completed the course.
  - d. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.
  - e. Records and reports. Nurse aide education programs approved by the department of inspections and appeals shall:
    - (1) Notify the department of inspections and appeals:
      1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
      2. When a facility or other training entity will no longer be offering nurse aide training courses.
      3. Whenever the person coordinating the training program is hired or terminates employment.
    - (2) Keep a list of faculty members and their qualifications available for department review.
    - (3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
    - (4) Complete a lesson plan for each unit which includes behavioral objectives, a topic outline and student activities and experiences.
    - (5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.
- 81.16(4) Nurse aide competency evaluation.** A competency evaluation program shall contain a written or oral portion and a skills demonstration portion.
- a. Notification to person. The department of inspections and appeals shall advise in advance any person who takes the competency evaluation that a record of the successful completion of the evaluation will be included in the state's nurse aide registry.
  - b. Content of the competency evaluation program.
    - (1) Written or oral examinations. The competency evaluation shall:
      1. Allow an aide to choose between a written and oral examination.
      2. Address each of the course requirements listed in 81.16(3) "b."

3. Be developed from a pool of test questions, only a portion of which is used in any one examination.

4. Use a system that prevents disclosure of both the pool of questions and the individual competency evaluations.

5. If oral, be read from a prepared text in a neutral manner.

6. Be tested for reliability and validity using a nationally recognized standard as determined by the department of education.

7. Be in English, unless the prevailing language used in the facility where a nurse aide will be working is other than English.

(2) Demonstration of skills. The skills demonstration evaluation shall consist of a demonstration of randomly selected items drawn from a pool consisting of tasks generally performed by nurse aides. This pool of skills shall include all of the personal care skills listed in 81.16(3) "b"(3).

c. Administration of the competency evaluation.

(1) The competency examination shall be administered and evaluated only by an entity approved by the department of inspections and appeals, which is neither a skilled nursing facility that participates in Medicare nor a nursing facility that participates in Medicaid.

(2) Charging nurse aides for competency testing is prohibited in accordance with 81.16(3) "c."

(3) The skills demonstration part of the evaluation shall be performed in a facility or laboratory setting comparable to the setting in which the person will function as a nurse aide and shall be administered and evaluated by a registered nurse with at least one year's experience in providing care for the elderly or the chronically ill of any age.

d. Facility proctoring of the competency evaluation.

(1) The competency evaluation may, at the nurse aide's option, be conducted at the facility in which the nurse aide is or will be employed unless the facility is prohibited from being a competency evaluation site.

(2) The department of inspections and appeals may permit the competency evaluation to be proctored by facility personnel if the department of inspections and appeals finds that the procedure adopted by the facility ensures that the competency evaluation program:

1. Is secure from tampering.

2. Is standardized and scored by a testing, educational, or other organization approved by the department of inspections and appeals.

3. Requires no scoring by facility personnel.

(3) The department of inspections and appeals shall retract the right to proctor nurse aide competency evaluations from facilities in which the department of inspections and appeals finds any evidence of impropriety, including evidence of tampering by facility staff.

e. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

f. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas which the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

g. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

h. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections and appeals. The department of inspections and appeals shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

**81.16(5) Registry of nurse aides.**

a. Establishment of registry. The department of inspections and appeals shall establish and maintain a registry of nurse aides that meets the following requirements. The registry:

(1) Shall include, at a minimum, the information required in 81.16(5) "c."

(2) Shall be sufficiently accessible to meet the needs of the public and health care providers promptly.

(3) Shall provide that any response to an inquiry that includes a finding of abuse, neglect, mistreatment of a resident or misappropriation of property also include any statement made by the nurse aide which disputes the finding.

b. Registry operation.

(1) Only the department of inspections and appeals may place on the registry findings of abuse, neglect, mistreatment of a resident or misappropriation of property.

(2) The department of inspections and appeals shall determine which persons:

1. Have successfully completed a nurse aide training and competency evaluation program or nurse aide competency evaluation program.

2. Have been deemed as meeting these requirements.

3. Do not qualify to remain on the registry because they have performed no nursing or nursing-related services for monetary compensation during a period of 24 consecutive months.

(3) The department of inspections and appeals shall not impose any charges related to registration on persons listed in the registry.

(4) The department of inspections and appeals shall provide information on the registry promptly.

c. Registry content.

(1) The registry shall contain at least the following information on each person who has successfully completed a nurse aide training and competency evaluation program or competency evaluation program which was approved by the department of inspections and appeals or who may function as a nurse aide because of having been deemed competent:

1. The person's full name.

2. Information necessary to identify each person.

3. The date the person became eligible for placement in the registry through successfully completing a nurse aide training and competency evaluation program or competency evaluation or by being deemed competent.

4. The following information on any finding by the department of inspections and appeals of abuse, neglect, mistreatment of residents or misappropriation of property by the person: documentation of the department of inspections and appeals' investigation, including the nature of the allegation and the evidence that led the department of inspections and appeals to conclude that the allegation was valid; the date of the hearing, if the person chose to have one, and its outcome; and a statement by the person disputing the allegation, if the person chooses to make one. This information must be included in the registry within ten working days of the finding and shall remain in the registry permanently, unless the finding was made in error, the person was found not guilty in a court of law, or the department of inspections and appeals is notified of the person's death.

5. A record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment or misappropriation of resident property.

(2) The registry shall remove entries for persons who have performed no nursing or nursing-related services for monetary compensation for a period of 24 consecutive months unless the person's registry

entry includes documented findings or convictions by a court of law of abuse, neglect, mistreatment or misappropriation of property.

*d.* Disclosure of information. The department of inspections and appeals shall:

(1) Disclose all of the information listed in 81.16(5) “c”(1), (3), and (4) to all requesters and may disclose additional information it deems necessary.

(2) Promptly provide persons with all information contained in the registry about them when adverse findings are placed on the registry and upon request. Persons on the registry shall have sufficient opportunity to correct any misstatements or inaccuracies contained in the registry.

*e.* Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry. The telephone number of the registry is (515)281-4963. The address is Nurse Aide Registry, Lucas State Office Building, Des Moines, Iowa 50319-0083.

(1) Persons employed as nurse aides shall complete Form 427-0496, Nurse Aide Registry Application, within the first 30 days of employment. This form shall be submitted to the department of inspections and appeals. Form 427-0496 may be obtained by calling or writing the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed Form 427-0496 to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, a letter will be sent to the nurse aide that includes all the information the registry has on the nurse aide. A nurse aide may obtain a copy of the information on the registry by writing the nurse aide registry and requesting the information. The letter requesting the information must include the nurse aide’s social security number, current or last facility of employment, date of birth and current mailing address and must be signed by the nurse aide.

**81.16(6) *Hearing.*** When there is an allegation of abuse against a nurse aide, the department of inspections and appeals shall investigate that allegation. When the investigation by the department of inspections and appeals makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections and appeals. The hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

**81.16(7) *Appeals.*** Adverse decisions made by the department of inspections and appeals in administering these rules may be appealed pursuant to department of inspections and appeals rules 481—Chapter 10.

This rule is intended to implement Iowa Code section 249A.4.

**441—81.17(249A) Termination procedures.** Rescinded IAB 5/10/95, effective 7/1/95.

**441—81.18(249A) Sanctions.**

**81.18(1) *Penalty for falsification of a resident assessment.*** An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty of not less than \$100 or more than \$1,000 for each falsified assessment. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not less than \$500 nor more than \$5,000 for each falsified assessment. These fines shall be administratively assessed by the department of inspections and appeals.

*a.* Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections and appeals or the director’s designee may consider evidence of the circumstances surrounding the violation, including, but not limited to, the following factors:

(1) The number of assessments willingly and knowingly falsified.

(2) The history of the individual relative to previous assessment falsifications.

(3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.  
(4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.

(5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

*b.* Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

*c.* Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections and appeals in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and department of inspections and appeals rules 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections and appeals may petition for judicial review in the manner provided by Iowa Code chapter 17A.

**81.18(2)** *Use of independent assessors.* If the department of inspections and appeals determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections and appeals may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

*a.* Criteria used to determine the need for independent assessors shall include:

(1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.

(2) The facility's response to the falsification of or causing resident assessments to be falsified.

(3) The method used to prepare facility staff to do resident assessments.

(4) The number of individuals involved in the falsification.

(5) The number of falsified resident assessments.

(6) The extent of harm to residents caused by the falsifications.

*b.* The department of inspections and appeals will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

*c.* The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections and appeals before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

*d.* Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

*e.* Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections and appeals for completing its own assessments.

(3) The department of inspections and appeals will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

*f.* Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections and appeals within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to department of inspections and appeals rules 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision which may be appealed to the director of the department of inspections and appeals pursuant to department of inspections and appeals rules 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

**81.18(3)** *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

**81.18(4)** *Failure to meet requirements for participation.* Rescinded IAB 5/10/95, effective 7/1/95. This rule is intended to implement Iowa Code section 249A.4.

**441—81.19(249A) Criteria related to the specific sanctions.** Rescinded IAB 5/10/95, effective 7/1/95.

**441—81.20(249A) Out-of-state facilities.** Payment will be made for care in out-of-state nursing facilities. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

**81.20(1)** *Out-of-state providers.* Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state-operated nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.6(16)“f”(1), whichever is lower.

*a.* Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.6(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

*b.* Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.6(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

**81.20(2)** Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

**81.20(3)** Effective December 1, 2009, payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

**81.20(4)** Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 8995B, IAB 8/11/10, effective 9/15/10]

**441—81.21(249A) Outpatient services.** Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, House File 479, section 132, subsection 1, paragraph “i.”

**441—81.22(249A) Rates for Medicaid eligibles.**

**81.22(1) Maximum client participation.** A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.6(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

**81.22(2) Beginning date of payment.** When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

This rule is intended to implement Iowa Code section 249A.4.  
[ARC 1806C, IAB 1/7/15, effective 3/1/15]

**441—81.23(249A) State-funded personal needs supplement.** A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

**441—81.24 to 81.30** Reserved.

DIVISION II  
ENFORCEMENT OF COMPLIANCE

PREAMBLE

These rules specify remedies that may be used when a nursing facility is not in substantial compliance with the requirements for participation in the Medicaid program. These rules also provide for ensuring prompt compliance and specify that these remedies are in addition to any others available under state or federal law.

**441—81.31(249A) Definitions.**

“CMS” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“Deficiency” means a nursing facility’s failure to meet a participation requirement.

“Department” means the Iowa department of human services.

“Immediate jeopardy” means a situation in which immediate corrective action is necessary because the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

“New admission” means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date.

Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor are they subject to the denial of payment.

“*Noncompliance*” means any deficiency that causes a facility to not be in substantial compliance.

“*Plan of correction*” means a plan developed by the facility and approved by the department of inspections and appeals which describes the actions the facility shall take to correct deficiencies and specifies the date by which those deficiencies shall be corrected.

“*Standard survey*” means a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with the requirements for participation.

“*Substandard quality of care*” means one or more deficiencies related to the participation requirements for resident behavior and facility practices, quality of life, or quality of care which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

“*Substantial compliance*” means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

“*Temporary management*” means the temporary appointment by the department of inspections and appeals of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility’s operation.

#### **441—81.32(249A) General provisions.**

**81.32(1) Purpose of remedies.** The purpose of remedies is to ensure prompt compliance with program requirements.

**81.32(2) Basis for imposition and duration of remedies.** The department of inspections and appeals, as the state survey agency under contract with the department, determines the remedy to be applied for noncompliance with program requirements. When the department of inspections and appeals chooses to apply one or more remedies specified in rule 441—81.34(249A), the remedies are applied on the basis of noncompliance found during surveys conducted by the department of inspections and appeals.

**81.32(3) Number of remedies.** The department of inspections and appeals may apply one or more remedies for each deficiency constituting noncompliance or for all deficiencies constituting noncompliance.

**81.32(4) Plan of correction requirement.**

*a.* Except as specified in paragraph “*b*,” regardless of which remedy is applied, each facility that has deficiencies with respect to program requirements shall submit a plan of correction for approval by the department of inspections and appeals.

*b.* A facility is not required to submit a plan of correction when the department of inspections and appeals determines the facility has deficiencies that are isolated and have a potential for minimal harm, but no actual harm has occurred.

**81.32(5) Disagreement regarding remedies.** If the department of inspections and appeals and CMS disagree on the decision to impose a remedy, the disagreement shall be resolved in accordance with rule 441—81.55(249A).

**81.32(6) Notification requirements.**

*a.* The department of inspections and appeals shall give the provider written notice of remedy, including the:

- (1) Nature of the noncompliance.
- (2) Which remedy is imposed.
- (3) Effective date of the remedy.
- (4) Right to appeal the determination leading to the remedy.

*b.* Except for civil money penalties and state monitoring imposed when there is immediate jeopardy, for all remedies specified in rule 441—81.34(249A) imposed when there is immediate

jeopardy, the notice shall be given at least two calendar days before the effective date of the enforcement action.

*c.* Except for civil money penalties and state monitoring, notice shall be given at least 15 calendar days before the effective date of the enforcement action in situations where there is no immediate jeopardy.

*d.* The 2- and 15-day notice periods begin when the facility receives the notice, but in no event will the effective date of the enforcement action be later than 20 calendar days after the notice is sent.

*e.* For civil money penalties, the notices shall be given in accordance with rules 441—81.48(249A) and 441—81.51(249A).

*f.* For state monitoring imposed when there is immediate jeopardy, no prior notice is required.

**81.32(7) Informal dispute resolution.**

*a.* Opportunity to refute survey findings.

(1) For nonfederal surveys, the department of inspections and appeals (DIA) shall offer a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

(2) For a federal survey, the Centers for Medicare and Medicaid Services (CMS) offers a facility an informal opportunity, at the facility's request, to dispute survey findings upon the facility's receipt of the official statement of deficiencies.

*b.* Delay of enforcement action.

(1) Failure of DIA or CMS, as appropriate, to complete informal dispute resolution timely cannot delay the effective date of any enforcement action against the facility.

(2) A facility may not seek a delay of any enforcement action against it on the grounds that informal dispute resolution has not been completed before the effective date of the enforcement action.

*c.* If a provider is subsequently successful, during the informal dispute resolution process, at demonstrating that deficiencies should not have been cited, the deficiencies are removed from the statement of deficiencies and any enforcement actions imposed solely as a result of those cited deficiencies are rescinded.

*d.* Notification. DIA shall provide the facility with written notification of the informal dispute resolution process.

**441—81.33(249A) Factors to be considered in selecting remedies.**

**81.33(1) Initial assessment.** In order to select the appropriate remedy, if any, to apply to a facility with deficiencies, the department of inspections and appeals shall determine the seriousness of the deficiencies.

**81.33(2) Determining seriousness of deficiencies.** To determine the seriousness of the deficiency, the department of inspections and appeals shall consider at least the following factors:

*a.* Whether a facility's deficiencies constitute:

- (1) No actual harm with a potential for minimal harm.
- (2) No actual harm with a potential for more than minimal harm, but not immediate jeopardy.
- (3) Actual harm that is not immediate jeopardy.
- (4) Immediate jeopardy to resident health or safety.

*b.* Whether the deficiencies:

- (1) Are isolated.
- (2) Constitute a pattern.
- (3) Are widespread.

**81.33(3) Other factors which may be considered in choosing a remedy within a remedy category.** Following the initial assessment, the department of inspections and appeals may consider other factors, which may include, but are not limited to, the following:

*a.* The relationship of the one deficiency to other deficiencies resulting in noncompliance.

*b.* The facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

**441—81.34(249A) Available remedies.** In addition to the remedy of termination of the provider agreement, the following remedies are available:

1. Temporary management.
2. Denial of payment for all new admissions.
3. Civil money penalties.
4. State monitoring.
5. Closure of the facility in emergency situations or transfer of residents, or both.
6. Directed plan of correction.
7. Directed in-service training.

**441—81.35(249A) Selection of remedies.**

**81.35(1) Categories of remedies.** Remedies specified in rule 441—81.34(249A) are grouped into categories and applied to deficiencies according to the severity of noncompliance.

**81.35(2) Application of remedies.** After considering the factors specified in rule 441—81.33(249A), if the department of inspections and appeals applies remedies, as provided in paragraphs 81.35(3) “a,” 81.35(4) “a,” and 81.35(5) “a,” for facility noncompliance, instead of, or in addition to, termination of the provider agreement, the department of inspections and appeals shall follow the criteria set forth in 81.35(3) “b,” 81.35(4) “b,” and 81.35(5) “b,” as applicable.

**81.35(3) Category 1.**

a. Category 1 remedies include the following:

- (1) Directed plan of correction.
- (2) State monitoring.
- (3) Directed in-services training.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 1 when there:

- (1) Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 1 to any deficiency.

**81.35(4) Category 2.**

a. Category 2 remedies include the following:

- (1) Denial of payment for new admissions.
- (2) Civil money penalties of \$50 to \$3,000 per day.

b. The department of inspections and appeals shall apply one or more of the remedies in Category 2 when there are:

- (1) Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy; or
- (2) One or more deficiencies that constitute actual harm that is not immediate jeopardy.

c. Except when the facility is in substantial compliance, the department of inspections and appeals may apply one or more of the remedies in Category 2 to any deficiency.

**81.35(5) Category 3.**

a. Category 3 remedies include the following:

- (1) Temporary management.
- (2) Immediate termination.
- (3) Civil money penalties of \$3,050 to \$10,000 per day.

b. When there is one or more deficiencies that constitute immediate jeopardy to resident health or safety, one or both of the following remedies shall be applied:

- (1) Temporary management.
- (2) Termination of the provider agreement.

In addition the department of inspections and appeals may impose a civil money penalty of \$3,050 to \$10,000 per day.

c. When there are widespread deficiencies that constitute actual harm that is not immediate jeopardy, the department of inspections and appeals may impose temporary management, in addition to Category 2 remedies.

**81.35(6) *Plan of correction.***

a. Except as specified in paragraph “b,” each facility that has a deficiency with regard to a requirement for long-term care facilities shall submit a plan of correction for approval by the department of inspections and appeals, regardless of:

- (1) Which remedies are applied.
- (2) The seriousness of the deficiencies.

b. When there are only isolated deficiencies that the department of inspections and appeals determines constitute no actual harm with a potential for minimal harm, the facility need not submit a plan of correction.

**81.35(7) *Appeal of a determination of noncompliance.***

a. A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections and appeals within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(1) A request for a hearing shall be made in writing to the department of inspections and appeals within 60 days from receipt of the notice.

(2) Hearings shall be conducted pursuant to department of inspections and appeals rules 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections and appeals as the final decision maker, with subject matter jurisdiction.

b. A facility may not appeal the choice of remedy, including the factors considered by the department of inspections and appeals in selecting the remedy.

c. A facility may not challenge the level of noncompliance found by the department of inspections and appeals, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections and appeals only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

d. Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

**441—81.36(249A) Action when there is immediate jeopardy.**

**81.36(1) *Terminate agreement or appoint temporary manager.*** If there is immediate jeopardy to resident health or safety, the department of inspections and appeals shall appoint a temporary manager to remove the immediate jeopardy or the provider agreement shall be terminated within 23 calendar days of the last date of the survey.

The rules for appointment of a temporary manager in an immediate jeopardy situation are as follows:

a. The department of inspections and appeals shall notify the facility that a temporary manager is being appointed.

b. If the facility fails to relinquish control to the temporary manager, the provider agreement shall be terminated within 23 calendar days of the last day of the survey if the immediate jeopardy is not removed. In these cases, state monitoring may be imposed pending termination.

c. If the facility relinquishes control to the temporary manager, the department of inspections and appeals shall notify the facility that, unless it removes the immediate jeopardy, its provider agreement shall be terminated within 23 calendar days of the last day of the survey.

d. The provider agreement shall be terminated within 23 calendar days of the last day of survey if the immediate jeopardy has not been removed.

**81.36(2) Other remedies.** The department of inspections and appeals may also impose other remedies, as appropriate.

**81.36(3) Notification of CMS.** In a nursing facility or dually participating facility, if the department of inspections and appeals finds that a facility's noncompliance poses immediate jeopardy to resident health or safety, the department of inspections and appeals shall notify CMS of the finding.

**81.36(4) Transfer of residents.** The department shall provide for the safe and orderly transfer of residents when the facility is terminated from participation.

**81.36(5) Notification of physicians and state board.** If the immediate jeopardy is also substandard quality of care, the department of inspections and appeals shall notify attending physicians and the Iowa board of nursing home administrators of the finding of substandard quality of care.

**441—81.37(249A) Action when there is no immediate jeopardy.**

**81.37(1) Termination of agreement or limitation of participation.** If a facility's deficiencies do not pose immediate jeopardy to residents' health or safety, and the facility is not in substantial compliance, the facility's provider agreement may be terminated or the facility may be allowed to continue to participate for no longer than six months from the last day of the survey if:

a. The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility's provider agreement;

b. The department of inspections and appeals has submitted a plan of correction approved by CMS; and

c. The facility agrees to repay payments received after the last day of the survey that first identified the deficiencies if corrective action is not taken in accordance with the approved plan of correction and posts bond acceptable to the department to guarantee the repayment.

**81.37(2) Termination.** If a facility does not meet the criteria for continuation of payment under subrule 81.37(1), the facility's provider agreement shall be terminated.

**81.37(3) Denial of payment.** Payment shall be denied for new admissions when the facility is not in substantial compliance three months after the last day of the survey.

**81.37(4) Failure to comply.** The provider agreement shall be terminated and all payments stopped to a facility for which participation was continued under subrule 81.37(1) if the facility is not in substantial compliance within six months of the last day of the survey.

**441—81.38(249A) Action when there is repeated substandard quality of care.**

**81.38(1) General.** If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies provided:

a. Payment for all new admissions shall be denied, as specified in rule 441—81.40(249A).

b. The department of inspections and appeals shall impose state monitoring, as specified in rule 441—81.42(249A) until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

**81.38(2) Repeated noncompliance.** For purposes of this rule, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact deficiency was repeated.

**81.38(3) Standard surveys to which this provision applies.** Standard surveys completed by the department of inspections and appeals on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

**81.38(4) Program participation.**

a. The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare, Medicaid or both programs will be considered).

b. Termination would allow the count of repeated substandard quality of care surveys to start over.

c. Change of ownership.

(1) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(2) In a facility that has undergone a change of ownership, the department of inspections and appeals may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the department of inspections and appeals that the poor past performance no longer is a factor due to the change in ownership.

**81.38(5) Compliance.** Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.

*a.* If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of the department of inspections and appeals that it is in substantial compliance with the requirements and that it will remain in substantial compliance for a period of time specified by the department of inspections and appeals.

*b.* A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it:

- (1) Alleges correction of the deficiencies cited in the most recent standard survey; or
- (2) Achieves compliance before the effective date of the remedies.

**441—81.39(249A) Temporary management.** The department of inspections and appeals may appoint a temporary manager from qualified applicants.

**81.39(1) Qualifications.** The temporary manager must:

*a.* Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the department of inspections and appeals.

*b.* Not have been found guilty of misconduct by any licensing board or professional society in any state.

*c.* Have, or a member of the manager's immediate family have, no financial ownership interest in the facility.

*d.* Not currently serve or, within the past two years, have served as a member of the staff of the facility.

**81.39(2) Payment of salary.** The temporary manager's salary:

*a.* Is paid directly by the facility while the temporary manager is assigned to that facility.

*b.* Shall be at least equivalent to the sum of the following:

(1) The prevailing salary paid by providers for positions of this type in the facility's geographic area.

(2) Additional costs that would have reasonably been incurred by the provider if the person had been in an employment relationship.

(3) Any other transportation and lodging costs incurred by the person in furnishing services under the arrangement up to the maximum per diem for state employees.

*c.* May exceed the amount specified in paragraph "b" if the department of inspections and appeals is otherwise unable to attract a qualified temporary manager.

**81.39(3) Failure to relinquish authority to temporary management.**

*a.* If a facility fails to relinquish authority to the temporary manager, the provider agreement shall be terminated in accordance with rule 441—81.57(249A).

*b.* A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

**81.39(4) Duration of temporary management.** Temporary management ends when the facility meets any of the conditions specified in subrule 81.56(3).

**441—81.40(249A) Denial of payment for all new admissions.**

**81.40(1) Optional denial of payment.** Except as specified in subrule 81.40(2), the denial of payment for all new admissions may be imposed when a facility is not in substantial compliance with the requirements.

**81.40(2) Required denial of payment.** Payment for all new admissions shall be denied when:

*a.* The facility is not in substantial compliance three months after the last day of the survey identifying the noncompliance; or

*b.* The department of inspections and appeals has cited a facility with substandard quality of care on the last three consecutive standard surveys.

**81.40(3) Resumption of payments.** Repeated instances of substandard quality of care. When a facility has repeated instances of substandard quality of care, payments to the facility resume on the date that:

*a.* The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

*b.* The department of inspections and appeals determines that the facility is capable of remaining in substantial compliance.

**81.40(4) Resumption of payments.** No repeated instances of substandard quality of care. When a facility does not have repeated instances of substandard quality of care, payments to the facility resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to the department of inspections and appeals.

**81.40(5) Restriction.** No payments to a facility are made for the period between the date that the denial of payment remedy is imposed and the date the facility achieves substantial compliance, as determined by the department of inspections and appeals.

**441—81.41(249A) Secretarial authority to deny all payments.**

**81.41(1) CMS option to deny all payment.** If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in rule 441—81.40(249A), CMS may deny any further payment to the state for all Medicaid residents in the facility. When CMS denies payment to the state, the department shall deny payment to the facility.

**81.41(2) Resumption of payment.** When CMS resumes payment to the state, the department shall also resume payment to the facility. The department shall make payments to the facility for the same periods for which payment is made to the state.

**441—81.42(249A) State monitoring.**

**81.42(1) State monitor.** A state monitor:

*a.* Oversees the correction of deficiencies specified by the department of inspections and appeals at the facility site and protects the facility's residents from harm.

*b.* Is an employee or a contractor of the department of inspections and appeals.

*c.* Is identified by the department of inspections and appeals as an appropriate professional to monitor cited deficiencies.

*d.* Is not an employee of the facility.

*e.* Does not function as a consultant to the facility.

*f.* Does not have an immediate family member who is a resident of the facility to be monitored.

**81.42(2) Use of state monitor.** A state monitor shall be used when the department of inspections and appeals has cited a facility with substandard quality of care deficiencies on the last three consecutive standard surveys.

**81.42(3) Discontinuance of state monitor.** State monitoring is discontinued when:

*a.* The facility has demonstrated that it is in substantial compliance with the requirement, and it will remain in compliance for a period of time specified by the department of inspections and appeals.

*b.* Termination procedures are completed.

**441—81.43(249A) Directed plan of correction.** The department of inspections and appeals or the temporary manager (with department of inspections and appeals' approval) may develop a plan of correction and require a facility to take action within specified time frames.

**441—81.44(249A) Directed in-service training.**

**81.44(1) Required training.** The department of inspections and appeals may require the staff of a facility to attend an in-service training program if:

*a.* The facility has a pattern of deficiencies that indicate noncompliance; and

b. Education is likely to correct the deficiencies.

**81.44(2) *Action following training.*** After the staff has received in-service training, if the facility has not achieved substantial compliance, the department of inspections and appeals may impose one or more other remedies.

**81.44(3) *Payment.*** The facility is responsible for the payment for the directed in-service training.

**441—81.45(249A) Closure of a facility or transfer of residents, or both.**

**81.45(1) *Closure during an emergency.*** In an emergency, the department and the department of inspections and appeals have the authority to:

a. Transfer Medicaid and Medicare residents to another facility; or

b. Close the facility and transfer the Medicaid and Medicare residents to another facility.

**81.45(2) *Required transfer in immediate jeopardy situations.*** When a facility's provider agreement is terminated for a deficiency that constitutes immediate jeopardy, the department arranges for the safe and orderly transfer of all Medicaid and Medicare residents to another facility.

**81.45(3) *All other situations.*** Except for immediate jeopardy situations, as specified in subrule 81.45(2), when a facility's provider agreement is terminated, the department arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

**441—81.46(249A) Civil money penalties—basis for imposing penalty.** The department of inspections and appeals may impose a civil money penalty for the number of days a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy.

The department of inspections and appeals may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

**441—81.47(249A) Civil money penalties—when penalty is collected.**

**81.47(1) *When facility requests a hearing.***

a. A facility shall request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time limit specified in subrule 81.35(7).

b. If a facility requests a hearing within the time specified in subrule 81.35(7), the department of inspections and appeals initiates collection of the penalty when there is a final administrative decision that upholds the department of inspections and appeals' determination of noncompliance after the facility achieves substantial compliance or is terminated.

**81.47(2) *When facility does not request a hearing.*** If a facility does not request a hearing, in accordance with subrule 81.47(1), the department of inspections and appeals initiates collection of the penalty when the facility:

a. Achieves substantial compliance; or

b. Is terminated.

**81.47(3) *When facility waives a hearing.*** If a facility waives its right to a hearing in writing, as specified in rule 441—81.49(249A), the department of inspections and appeals initiates collection of the penalty when the facility:

a. Achieves substantial compliance; or

b. Is terminated.

**81.47(4) *Accrual and computation of penalties.*** Accrual and computation of penalties for a facility that:

a. Requests a hearing or does not request a hearing as specified in rule 441—81.50(249A);

b. Waives its right to a hearing in writing, as specified in subrule 81.49(2) and rule 441—81.50(249A).

**81.47(5) *Collection.*** The collection of civil money penalties is made as provided in rule 441—81.52(249A).

**441—81.48(249A) Civil money penalties—notice of penalty.** The department of inspections and appeals shall notify the facility of intent to impose a civil money penalty in writing. The notice shall include, at a minimum, the following information:

1. The nature of the noncompliance.
2. The statutory basis for the penalty.
3. The amount of penalty per day of noncompliance.
4. Any factors specified in subrule 81.50(6) that were considered when determining the amount of the penalty.
5. The date on which the penalty begins to accrue.
6. When the penalty stops accruing.
7. When the penalty is collected.
8. Instructions for responding to the notice, including a statement of the facility's right to a hearing, and the implication of waiving a hearing, as provided in rule 441—81.49(249A).

**441—81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount.**

**81.49(1) Waiver of a hearing.** The facility may waive the right to a hearing, in writing, within 60 days from the date of the notice of intent to impose the civil money penalty.

**81.49(2) Reduction of penalty amount.**

*a.* If the facility waives its right to a hearing, the department of inspections and appeals reduces the civil money penalty amount by 35 percent.

*b.* If the facility does not waive its right to a hearing, the civil money penalty is not reduced by 35 percent.

**441—81.50(249A) Civil money penalties—amount of penalty.**

**81.50(1) Amount of penalty.** The penalties are within the following ranges, set at \$50 increments:

*a.* Upper range—\$3,050 to \$10,000. Penalties in the range of \$3,050 to \$10,000 per day are imposed for deficiencies constituting immediate jeopardy, as specified in 81.50(4) "b."

*b.* Lower range—\$50 to \$3,000. Penalties in the range of \$50 to \$3,000 per day are imposed for deficiencies that do not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm.

**81.50(2) Basis for penalty amount.** The amount of penalty is based on the department of inspections and appeals' assessment of factors listed in subrule 81.50(6).

**81.50(3) Decreased penalty amounts.** Except as specified in 81.50(4) "b," if immediate jeopardy is removed, but the noncompliance continues, the department of inspections and appeals shall shift the penalty amount to the lower range.

**81.50(4) Increased penalty amounts.**

*a.* Before the hearing, the department of inspections and appeals may propose to increase the penalty amount for facility noncompliance which, after imposition of a lower level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

*b.* The department of inspections and appeals shall increase the penalty amount for any repeated deficiencies for which a lower level penalty amount was previously imposed, regardless of whether the increased penalty amount would exceed the range otherwise reserved for nonimmediate jeopardy deficiencies.

*c.* Repeated deficiencies are deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey.

**81.50(5) Review of the penalty.** When an administrative law judge (or director of the department of inspections and appeals) finds that the basis for imposing a civil money penalty exists, the administrative law judge (or director) may not:

*a.* Set a penalty of zero or reduce a penalty to zero.

*b.* Review the exercise of discretion by the department of inspections and appeals to impose a civil money penalty.

c. Consider any factors in reviewing the amount of the penalty other than those specified in subrule 81.50(6).

**81.50(6) *Factors affecting the amount of penalty.*** In determining the amount of penalty, the department of inspections and appeals shall take into account the following factors:

- a. The facility's history of noncompliance, including repeated deficiencies.
- b. The facility's financial condition.
- c. The factors specified in rule 441—81.33(249A).
- d. The facility's degree of culpability. Culpability includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.

**81.50(7) *Authority to settle penalties.*** The department of inspections and appeals has the authority to settle cases at any time before the evidentiary hearing.

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**441—81.51(249A) Civil money penalties—effective date and duration of penalty.**

**81.51(1) *When penalty begins to accrue.*** The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by the department of inspections and appeals.

**81.51(2) *Duration of penalty.*** The civil money penalty is computed and collectible, as specified in rules 441—81.47(249A) and 441—81.52(249A), for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination when:

- a. The department of inspections and appeals' decision of noncompliance is upheld after a final administrative decision;
- b. The facility waives its right to a hearing in accordance with rule 441—81.49(249A); or
- c. The time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

**81.51(3) *Penalty due.*** The entire accrued penalty is due and collectible, as specified in the notice sent to the provider under subrules 81.51(4) and 81.54(5).

**81.51(4) *Notice after facility achieves compliance.*** When a facility achieves substantial compliance, the department of inspections and appeals shall send a separate notice to the facility containing:

- a. The amount of penalty per day;
- b. The number of days involved;
- c. The total amount due;
- d. The due date of the penalty; and
- e. The rate of interest assessed on the unpaid balance beginning on the due date, as provided in rule 441—81.52(249A).

**81.51(5) *Notice to terminated facility.*** In the case of a terminated facility, the department of inspections and appeals shall send this penalty information after the:

- a. Final administrative decision is made;
- b. Facility has waived its right to a hearing in accordance with rule 441—81.49(249A); or
- c. Time for requesting a hearing has expired and the department of inspections and appeals has not received a hearing request from the facility.

**81.51(6) *Accrual of penalties when there is no immediate jeopardy.***

a. In the case of noncompliance that does not pose immediate jeopardy, the daily accrual of civil money penalties is imposed for the days of noncompliance prior to the notice specified in rule 441—81.48(249A) and an additional period of no longer than six months following the last day of the survey.

b. After the period specified in paragraph "a," if the facility has not achieved substantial compliance, the provider agreement may be terminated.

**81.51(7) *Accrual of penalties when there is immediate jeopardy.***

a. When a facility has deficiencies that pose immediate jeopardy, the provider agreement shall be terminated within 23 calendar days after the last day of the survey if the immediate jeopardy remains.

b. The accrual of the civil money penalty stops on the day the provider agreement is terminated.

**81.51(8) Documenting substantial compliance.**

*a.* If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to the department of inspections and appeals that substantial compliance was achieved on a date preceding the revisit, penalties only accrue until that date of correction for which there is written credible evidence.

*b.* If an on-site revisit is not necessary to confirm substantial compliance, penalties only accrue until the date of correction for which the department of inspections and appeals receives and accepts written credible evidence.

**441—81.52(249A) Civil money penalties—due date for payment of penalty.****81.52(1) When payments are due.**

*a.* A civil money penalty payment is due 15 days after a final administrative decision is made when:

- (1) The facility achieves substantial compliance before the final administrative decision; or
- (2) The effective date of termination occurs before the final administrative decision.

*b.* A civil money penalty is due 15 days after the time period for requesting a hearing has expired and a hearing request was not received when:

- (1) The facility achieves substantial compliance before the hearing request was due; or
- (2) The effective date of termination occurs before the hearing request was due.

*c.* A civil money penalty payment is due 15 days after receipt of the written request to waive a hearing when:

- (1) The facility achieved substantial compliance before the department of inspections and appeals received the written waiver of hearing; or
- (2) The effective date of termination occurs before the department of inspections and appeals received the written waiver of hearing.

*d.* A civil money penalty payment is due 15 days after substantial compliance is achieved when:

- (1) The final administrative decision is made before the facility came into compliance;
- (2) The facility did not file a timely hearing request before it came into substantial compliance; or
- (3) The facility waived its right to a hearing before it came into substantial compliance.

*e.* A civil money penalty payment is due 15 days after the effective date of termination, if before the effective date of termination:

- (1) The final administrative decision was made;
- (2) The time for requesting a hearing has expired and the facility did not request a hearing; or
- (3) The facility waived its right to a hearing.

*f.* In the cases specified in paragraph “d,” the period of noncompliance may not extend beyond six months from the last day of the survey.

**81.52(2) Deduction of penalty from amount owed.** The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

**81.52(3) Interest.** Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

**81.52(4) Penalties collected by the department.** Rescinded IAB 3/9/11, effective 4/1/11.  
[ARC 9402B, IAB 3/9/11, effective 4/1/11]

**441—81.53(249A) Use of penalties collected by the department.** Civil money penalties collected by the department shall be applied to the protection of the health or property of residents of facilities that the department of inspections and appeals finds deficient. Funds may be used for:

1. Payment for the cost of relocating residents to other facilities;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents; and

4. Funding of projects to improve the quality of life or quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166.  
[ARC 9402B, IAB 3/9/11, effective 4/1/11]

**441—81.54(249A) Continuation of payments to a facility with deficiencies.**

**81.54(1) Criteria.**

a. The department may continue payments to a facility that is not in substantial compliance for the periods specified in subrule 81.54(3) if the following criteria are met:

- (1) The department of inspections and appeals finds that it is more appropriate to impose alternative remedies than to terminate the facility;
- (2) The department of inspections and appeals has submitted a plan and timetable for corrective action approved by CMS; and
- (3) The facility agrees to repay the department for all payments received under this provision if corrective action is not taken in accordance with the approved plan and timetable for corrective action and posts a bond acceptable to the department to guarantee agreement to repay.

b. The facility provider agreement may be terminated before the end of the correction period if the criteria in 81.54(1)“a” are not met.

**81.54(2) Cessation of payments.** If termination is not sought, either by itself or along with another remedy or remedies, or any of the criteria in 81.54(1)“a” are not met or agreed to by either the facility or the department, the facility shall receive no payments, as applicable, from the last day of the survey.

**81.54(3) Period of continued payments.** If the conditions in 81.54(1)“a” are met, the department may continue payments to a facility with noncompliance that does not constitute immediate jeopardy for up to six months from the last day of the survey.

**81.54(4) Failure to achieve substantial compliance.** If the facility does not achieve substantial compliance by the end of the period specified in subrule 81.54(3), the provider agreement for the facility may be terminated.

**441—81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy.** This rule applies when CMS and the department of inspections and appeals disagree over findings of noncompliance or application of remedies.

**81.55(1) Disagreement over whether facility has met requirements.**

a. The department of inspections and appeals’ finding of noncompliance takes precedence when:

- (1) CMS finds the facility is in substantial compliance with the participation requirements; and
- (2) The department of inspections and appeals finds the facility has not achieved substantial compliance.

b. CMS’s findings of noncompliance take precedence when:

- (1) CMS finds that a facility has not achieved substantial compliance; and
- (2) The department of inspections and appeals finds the facility is in substantial compliance with the participation requirements.

c. When CMS’s survey findings take precedence, CMS may:

- (1) Impose any of the alternative remedies specified in rule 441—81.34(249A);
- (2) Terminate the provider agreement subject to the applicable conditions of rule 441—81.54(249A); and
- (3) Stop federal financial participation to the department for a nursing facility.

**81.55(2) Disagreement over decision to terminate.**

a. CMS’s decision to terminate the participation of a facility takes precedence when:

- (1) Both CMS and the department of inspections and appeals find that the facility has not achieved substantial compliance; and
- (2) CMS, but not the department of inspections and appeals, finds that the facility’s participation should be terminated. CMS will permit continuation of payment during the period prior to the effective date of termination, not to exceed six months, if the applicable conditions of rule 441—81.54(249A) are met.

*b.* The department of inspections and appeals' decision to terminate a facility's participation and the procedures for appealing the termination take precedence when:

(1) The department of inspections and appeals, but not CMS, finds that a facility's participation should be terminated; and

(2) The department of inspections and appeals' effective date for the termination of the nursing facility's provider agreement is no later than six months after the last day of survey.

**81.55(3) *Disagreement over timing of termination of facility.*** The department of inspections and appeals' timing of termination takes precedence if it does not occur later than six months after the last day of the survey when both CMS and the department of inspections and appeals find that:

*a.* A facility is not in substantial compliance; and

*b.* The facility's participation should be terminated.

**81.55(4) *Disagreement over remedies.***

*a.* When CMS or the department of inspections and appeals, but not both, establishes one or more remedies, in addition to or as an alternative to termination, the additional or alternative remedies will also apply when:

(1) Both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance; and

(2) Both CMS and the department of inspections and appeals find that no immediate jeopardy exists.

*b.* When CMS and the department of inspections and appeals establish one or more remedies, in addition to or as an alternative to termination, only the CMS remedies apply when both CMS and the department of inspections and appeals find that a facility has not achieved substantial compliance.

**81.55(5) *One decision.*** Regardless of whether CMS's or the department of inspections and appeals' decision controls, only one noncompliance and enforcement decision is applied to the Medicaid agreement, and for a dually participating facility, that same decision will apply to the Medicare agreement.

#### **441—81.56(249A) Duration of remedies.**

**81.56(1) *Remedies continue.*** Except as specified in subrule 81.56(2), alternative remedies continue until:

*a.* The facility has achieved substantial compliance as determined by the department of inspections and appeals based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; or

*b.* The provider agreement is terminated.

**81.56(2) *State monitoring.*** In the cases of state monitoring and denial of payment imposed for repeated substandard quality of care, remedies continue until:

*a.* The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance; or

*b.* The provider agreement is terminated.

**81.56(3) *Temporary management.*** In the case of temporary management, the remedy continues until:

*a.* The department of inspections and appeals determines that the facility has achieved substantial compliance and is capable of remaining in substantial compliance;

*b.* The provider agreement is terminated; or

*c.* The facility which has not achieved substantial compliance reassumes management control. In this case, the department of inspections and appeals initiates termination of the provider agreement and may impose additional remedies.

**81.56(4) *Facility in compliance.*** If the facility can supply documentation acceptable to the department of inspections and appeals that it was in substantial compliance, and was capable of remaining in substantial compliance, if necessary, on a date preceding that of the revisit, the remedies terminate on the date that the department of inspections and appeals can verify as the date that substantial compliance was achieved.

**441—81.57(249A) Termination of provider agreement.**

**81.57(1) *Effect of termination.*** Termination of the provider agreement ends payment to the facility and any alternative remedy.

**81.57(2) *Basis of termination.***

*a.* A facility's provider agreement may be terminated if a facility:

(1) Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present; or

(2) Fails to submit an acceptable plan of correction within the time frame specified by the department of inspections and appeals.

*b.* A facility's provider agreement shall be terminated if a facility:

(1) Fails to relinquish control to the temporary manager, if that remedy is imposed by the department of inspections and appeals; or

(2) Does not meet the eligibility criteria for continuation of payment as set forth in 81.37(1) "a."

**81.57(3) *Notice of termination.*** Before a provider agreement is terminated, the department of inspections and appeals shall notify the facility and the public:

*a.* At least two calendar days before the effective date of termination for a facility with immediate jeopardy deficiencies; and

*b.* At least 15 calendar days before the effective date of termination for a facility with nonimmediate jeopardy deficiencies that constitute noncompliance.

These rules are intended to implement Iowa Code section 249A.4.

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- <sup>1</sup> Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.
- <sup>2</sup> Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.
- <sup>3</sup> Effective date of 81.13(7) "c"(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.
- <sup>4</sup> Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.
- <sup>5</sup> At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

## OBJECTION

At its meeting held August 11, 1992, the Administrative Rules Review Committee voted to object to the amendments published in **ARC 3069A** on the grounds the amendments are unreasonable. This filing is published in IAB Vol. XIV No. 253 (06-10-92). It is codified as an amendment to paragraph 441 IAC 81.13(7)“c”(1).

In brief, this filing provides that care facilities shall not employ persons who have been found guilty in a court of law of abusing, neglecting or mistreating facility residents, or who have had a “finding” entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. Additionally, the filing eliminates a previous provision which allowed the Department of Inspections and Appeals some discretion in deciding whether the lifetime ban on employment should be applied.

This language originated in the federal government which mandated that the department adopt these provisions or possibly face sanctions. The Committee does not believe these amendments are an improvement to Iowa’s system and has the following objection. The Committee believes that the amendments published in **ARC 3069A** are unreasonable because of the inconsistency in the burdens of proof and the levels of procedural safeguards in the two proceedings. A facility employee may either be found guilty in a court of law or have an administrative finding entered into the registry. In either case the result is the same, the employee is permanently banned from further employment in a care facility; however, the two paths to the result are significantly different. The first proceeding is a criminal tribunal in which the burden of proof is “beyond a reasonable doubt.” The second proceeding is a simple administrative hearing in which the burden is “preponderance of the evidence.” The two proceedings also differ in the level of many other due process protections accorded to the individual. A criminal proceeding provides the accused with the opportunity for a trial by jury, competent legal counsel, strict rules of evidence and many procedural protections not present in administrative hearings. It should also be noted that the penalty in this situation—a lifetime ban on employment—is more serious than is usually imposed in contested cases. In licensee discipline cases, a license can be revoked, but the possibility of reinstatement exists; under this new rule no reinstatement is allowed, the facility employee is banned from employment no matter how serious or minor the offense or how far in the past it occurred. Because of the magnitude of this penalty, the Committee believes that the accused should be provided with greater procedural protections than are generally found in administrative hearings.

The Committee also believes this filing is unreasonable because it eliminates the discretion accorded to the Department of Inspections and Appeals to not apply the lifetime ban on employment. Under the previous rule, the department’s discretion in applying the employment ban acted as a safeguard against unjust results. It recognized that a person would make amends for past offenses and earn a second chance. The provision was a genuine improvement in the process; it recognized that flexibility was needed in government decision making and that some decisions should be made on a case-by-case basis. There does not appear to be any rational basis to justify the elimination of this safeguard and, therefore, the Committee believes this action to be unreasonable.

CHAPTER 109  
CHILD CARE CENTERS

[Filed as Chapter 108, 2/14/75 and renumbered 7/1/75]

[Prior to 7/1/83, Social Services[770] Ch 109]

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to specify minimum requirements for licensed child care centers and preschools and to define those child-caring environments that are governed by the licensing standards. The licensing standards govern licensing procedures, administration, parental participation, personnel, records, health and safety policies, physical facilities, activity programs, and food services.

**441—109.1(237A) Definitions.**

“*Adult*” means a person 18 years of age or older.

“*Child*” means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

“*Child care*” means the care, supervision, or guidance of a child by a person other than the parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis in a place other than the child’s home, but does not include care, supervision, or guidance of a child by any of the following:

1. An instructional program administered by a public or nonpublic school system accredited by the department of education or the state board of regents or a program provided under Iowa Code sections 279.49 and 280.3A.
2. Any of the following church-related programs:
  - An instructional program.
  - A youth program other than a preschool, before or after school child care program, or other child care program.
  - A program providing care to children on church premises while the children’s parents are attending church-related or church-sponsored activities on the church premises.
3. Short-term classes of less than two weeks’ duration held between school terms or during a break within a school term.
4. A child care center for sick children operated as part of a pediatrics unit in a hospital licensed by the department of inspections and appeals pursuant to Iowa Code chapter 135B.
5. A program operated not more than one day per week by volunteers that meets all the following conditions:
  - Not more than 11 children are served per volunteer.
  - The program operates for less than 4 hours during any 24-hour period.
  - The program is provided at no cost to the children’s parent, guardian, or custodian.
6. A nationally accredited camp.
7. A program administered by a political subdivision of the state which is primarily for recreational or social purposes and is limited to children who are five years of age or older and attending school.
8. An instructional program for children at least four years of age who are attending prekindergarten, as defined by the state board of education, or a higher grade level, administered by a nonpublic school system which is not accredited by the department of education or the state board of regents.
9. An after-school program continuously offered throughout the school year to children who are at least five years of age and enrolled in school and attend the program intermittently, or a summer-only program for such children. The program must be provided through a nominal membership fee or at no cost.

10. A special activity program which meets less than four hours per day for the sole purpose of the special activity. Special activity programs include but are not limited to music or dance classes, organized athletic or sports programs, recreational classes, scouting programs, and hobby or craft clubs or classes.

11. A structured program for the purpose of providing therapeutic, rehabilitative, or supervisory services to children under any of the following:

- A purchase of service or managed care contract with the department.
- A contract approved by a local decategorization governance board.
- An arrangement approved by a juvenile court order.

12. Care provided on site to children of parents residing in an emergency, homeless, or domestic violence shelter.

13. A child care facility providing respite care to a licensed foster family home for a period of 24 hours or more to a child who is placed with that licensed foster family home.

14. A program offered to a child whose parent, guardian, or custodian is engaged solely in a recreational or social activity, remains immediately available and accessible on the physical premises on which the child's care is provided, and does not engage in employment while the care is provided. However, if the recreational or social activity is provided in a fitness center or on the premises of a nonprofit organization, the parent, guardian, or custodian of the child may be employed to teach or lead the activity.

*"Child care center"* or *"center"* means a facility providing child day care for seven or more children, except when the facility is registered as a child development home. For the purposes of this chapter, the word *"center"* shall apply to a child care center or preschool, unless otherwise specified.

*"Child care facility"* or *"facility"* means a child care center, a preschool, or a registered child development home.

*"Department"* means the department of human services.

*"Direct responsibility for child care"* means being charged with the care, supervision, or guidance of a child.

*"Extended evening care"* means child care provided by a child care center between the hours of 9 p.m. and 5 a.m.

*"Facility"* means a building or physical plant established for the purpose of providing child day care.

*"Get-well center"* means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

*"Involvement with child care"* means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

*"National Health and Safety Performance Standards"* means the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs produced by the American Public Health Association and the American Academy of Pediatrics with the support of the Maternal and Child Health Bureau, Department of Health and Human Services.

*"Parent"* means parent or legal guardian.

*"Person subject to an evaluation"* means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for licensure or is licensed.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.

*"Preschool"* means a child day care facility which provides care to children aged three through five, for periods of time not exceeding three hours per day. The preschool's program is designed to help the children develop intellectual, social and motor skills, and to extend their interest in and understanding of the world about them.

“*Regulatory fee*” means the amount payable to the department for licensure of a child care center based on the capacity of the center.

“*Requesting entity*” means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can have involvement with child care. The requesting entity must be a child care facility as defined in Iowa Code chapter 237A.

“*Transgression*” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

“*Unrestricted access*” means that a person has contact with a child alone or is directly responsible for child care.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 0030C, IAB 3/7/12, effective 5/1/12; ARC 1809C, IAB 1/7/15, effective 3/1/15]

#### **441—109.2(237A) Licensure procedures.**

##### **109.2(1) Application for license.**

a. Any adult or agency has the right to apply for a license. The application for a license shall be made to the department on Form 470-0722, Application for a License to Operate a Child Care Center, provided by the department.

b. Requested reports including the fire marshal’s report and other information relevant to the licensing determination shall be furnished to the department upon application and renewal. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings under 661—Chapter 5 is considered appropriate for use by a child care facility.

c. When a center makes a sufficient application for an initial license, it may operate for a period of up to 120 calendar days from the date of issuance of Form 470-4690, Permission to Open Without a License, pending a final licensing decision. A center has made a sufficient application when it has submitted the following to the department:

- (1) An application for a license.
- (2) An approved fire marshal’s report.
- (3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.
- (4) Information sufficient to determine that the center director meets minimum personnel qualifications.

d. Applicants shall be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued Form 470-4690, Permission to Open Without a License, the applicant shall be notified of approval or denial within 120 calendar days of the date of issuance of Form 470-4690.

(2) No full or provisional license shall be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(7).

e. The department shall not act on a licensing application for 12 months after an applicant’s child care center license has been denied or revoked.

f. When the department has denied or revoked a license, the applicant or person shall be prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

##### **109.2(2) License.**

a. An applicant showing full compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in

subrule 109.2(7) to the department by the date due, shall be issued a license for 24 months. In determining whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department shall make the final decision.

*b.* A new license shall be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

*c.* A new license shall be applied for when another adult or agency assumes ownership or legal responsibility for the center.

**109.2(3) Provisional license.**

*a.* A provisional license may be issued or a previously issued license may be reduced to a provisional license for a period up to one year when the center does not meet all standards imposed by law and these rules.

*b.* A provisional license shall be renewable when written plans giving specific dates for completion to bring the center up to standards are submitted to and approved by the department. A provisional license shall not be reissued for more than two consecutive years when the lack of compliance with the same standards has not been corrected within two years.

*c.* When the center submits documentation or it can otherwise be verified that the center fully complies with all standards imposed by law or these rules, the license shall be upgraded to a full license.

**109.2(4) Denial.** Initial applications or renewals shall be denied when:

*a.* The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

*b.* The center is operating in a manner which the department determines impairs the safety, health, or well-being of children in care.

*c.* A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

*d.* Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

*e.* The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

*f.* The regulatory fee as specified in subrule 109.2(7) is not received by the department's division of fiscal management by the due date indicated on Form 470-4834, Child Care Center Licensing Fee Invoice.

**109.2(5) Revocation and suspension.** A license shall be revoked or suspended if corrective action has not been taken when:

*a.* The center does not comply with center licensing laws or these rules.

*b.* The center is operating in a manner which the department determines impairs the safety, health, or well-being of the children in care.

*c.* A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

*d.* Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

*e.* The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal in 661—Chapter 5 or Iowa Code chapter 100 or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

*f.* The regulatory fee as specified in subrule 109.2(7) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

**109.2(6) Adverse actions.**

*a.* Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7.

*b.* An applicant or licensee affected by an adverse action may request a hearing by means of a written request directed to the Department of Human Services, Appeals Section, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The request shall be submitted within 30 days after the date the department mailed the official notice containing the nature of the denial, revocation, or suspension.

*c.* A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license shall be conspicuously posted at the main entrance to the facility where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny, suspend or revoke the license. If the action to deny, suspend, or revoke is upheld, the center shall return the license to the department.

*d.* If the center's license is denied, suspended or revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides child care. The center shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

**109.2(7) Regulatory fees.** For relicensures with an effective date on or after August 1, 2010, as indicated on the license certificate, and for initial applications for licensure submitted on or after June 1, 2010, a fee based upon center capacity is due to the department before the issuance of the license in accordance with this subrule.

*a. Fee structure.* The amount of the fee is based on the capacity of the center as indicated below:

<u>Center Capacity</u>	<u>Fee Amount</u>
0 to 20 children	\$50
21 to 50 children	\$75
51 to 100 children	\$100
101 to 150 children	\$125
151 or more children	\$150

*b. Determination of capacity.* The licensing consultant shall determine center capacity by dividing the amount of usable space by the amount of space required per child, as specified in subrule 109.11(1) and subparagraphs 109.11(3) "a"(2) and (3). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) and subparagraphs 109.11(3) "a"(2) and (3) are maintained.

*c. Notification.* Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee shall sign and provide Form 470-4834, Child Care Center Licensing Fee Invoice, to the center.

*d. Payment.* The center shall return Form 470-4834 to the department with the licensing fee payment within 30 calendar days from the date of the licensing consultant's or designee's signature on Form 470-4834. Payment may be in the form of cash, check, money order, or cashier's check.

(1) Payment must be received before the department will issue a full or provisional license.

(2) Regulatory fees are nonrefundable and nontransferable.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14]

**441—109.3(237A) Inspection and evaluation.** The department shall conduct an on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and shall determine compliance with licensing standards imposed by licensing laws and these rules when a complaint is received.

**109.3(1)** At least one unannounced on-site visit shall be conducted each calendar year.

**109.3(2)** After each visit and complaint, the department shall document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

**109.3(3)** The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and complaints shall be available to the public. However, the identity of the complainant shall be withheld unless expressly waived by the complainant.

**441—109.4(237A) Administration.**

**109.4(1) Purpose and objectives.** Incorporated and unincorporated centers shall submit a written statement of purpose and objectives. The plan and practices of operation shall be consistent with this statement.

**109.4(2) Required written policies.** The child care center owner, board or director shall:

- a. Develop fee policies and financial agreements for the children served.
- b. Develop and implement policies for enrollment and discharge of children, field trips and non-center activities, transportation, discipline, nutrition, and health and safety policies.
- c. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.
- d. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of 441—Chapter 109 where applicable to staff.
- e. Develop and implement a written plan for ongoing training and staff development in compliance with professional growth and development requirements established by the department in rule 441—109.7(237A).

f. Make available for review a copy of the center policies and program to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.

g. Develop and implement a policy for responding to incidents of biting that includes the following elements.

- (1) An explanation of the center's perspective on biting.
- (2) A description of how the center will respond to individual biting incidents and episodes of ongoing biting.
- (3) A description of how the center will assess the adequacy of caregiver supervision and the context and the environment in which the biting occurred.
- (4) A description of how the center will respond to the individual child or caregiver who was bitten.
- (5) A description of the process for notification of parents of children involved in the incident.
- (6) A description of how the incident will be documented.
- (7) A description of how confidentiality will be protected.
- (8) A description of first-aid procedures that the center will use in response to biting incidents.

h. Develop a policy to ensure that people do not have unauthorized access to children at the center. The policy shall be subject to review for minimum safety standards by the licensing consultant. The policy shall include but is not limited to the following:

- (1) The center's criteria for allowing people to be on the property of the facility when children are present.
- (2) A description of how center staff will supervise and monitor people who are permitted on the property of the center when children are present, but who have not been cleared for involvement with child care through the formal record check process as outlined in subrule 109.6(6). The description shall include definitions of "supervision" and "monitoring."
- (3) A description of how responsibility for supervision and monitoring of people in the center will be delegated to center staff, which includes provisions that address conflicts of interest.
- (4) A description of how the policy will be shared with parents, guardians, and custodians of all children who are enrolled at the center.

**109.4(3) Required postings.**

a. Postings are required for the certificate of license, notice of exposure of children to a communicable disease, and notice of action to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status. The center's license, reflecting current regulatory status, and all other required postings shall be conspicuously placed at the main entrance to the center. If the

center is located in a building used for additional purposes and shares the main entrance to the building, the required postings shall be conspicuously placed in the center in an area that is frequented daily by parents or the public.

*b.* Postings are required for mandatory reporter requirements, the notice of availability of the handbook required in subrule 109.4(5), and the program activities and shall be placed in an area that is frequented daily by parents or the public.

**109.4(4) *Mandatory reporters.*** Requirements and procedures for mandatory reporting of suspected child abuse as defined in Iowa Code section 232.69 shall be posted where they can be read by staff and parents. Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

**109.4(5) *Handbook.*** A copy of Form SS-0711, Child Care Centers and Preschools Licensing Standards and Procedures, shall be available in the center, and a notice stating that a copy is available for review upon request from the center director shall be conspicuously posted. The name, office mailing address and telephone number of the child care consultant shall be included in the notice.

**109.4(6) *Certificate of license.*** The child care license shall be posted in a conspicuous place and shall state the particular premises in which child care may be offered and the number of children who may be cared for at any one time. Notwithstanding the requirements in rule 441—109.8(237A), no greater number of children than is authorized by the license shall be cared for at any one time.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14]

#### **441—109.5(237A) Parental participation.**

**109.5(1) *Unlimited access.*** Parents shall be afforded unlimited access to their children and to the provider caring for their children during the center's hours of operation or whenever their children are in the care of a provider, unless parental contact is prohibited by court order. The provider shall inform all parents of this policy in writing at the time the child is admitted to the center.

**109.5(2) *Parental evaluation.*** If requested by the department, centers shall assist the department in conducting an annual survey of parents being served by their center by providing to parents Form 470-3409, Parent Survey: Child Care Centers. The department shall notify centers of the time frames for distribution and completion of the survey and the procedures for returning the survey to the department. The purpose of the survey shall be to increase parents' understanding of developmentally appropriate and safe practice, solicit statewide information regarding parental satisfaction with the quality of care being provided to children and obtain the parents' perspective regarding the center's compliance with licensing requirements.

**441—109.6(237A) Personnel.** The board or director of the center shall develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

**109.6(1) *Center director requirements.*** Centers that have multiple sites shall have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and administering programs. The director shall ensure services are provided for the children within the framework of the licensing requirements and the center's statement of purpose and objectives. The center director shall have overall responsibility for carrying out the program and ensuring the safety and protection of the children. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the director meets the following minimum qualifications:

- a.* Is at least 21 years of age.
- b.* Has obtained a high school diploma or passed a general education development test.
- c.* Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, record keeping, or budgeting or has one year of administrative-related experience.

d. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's training for the mandatory reporting of child abuse.

e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT- RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For directors in centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

**109.6(2) On-site supervisor.** The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of eight hours of the center's hours of operation. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the on-site supervisor meets the following minimum qualifications:

a. Is an adult.

b. Has obtained a high school diploma or passed a general education development test.

c. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's mandatory reporting of child abuse.

d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT- RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 75 points, a minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For on-site supervisors in centers predominantly serving children with special needs, the on-site supervisor may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For on-site supervisors in centers serving predominantly school-age children, the on-site supervisor may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

**109.6(3) Director and on-site supervisor functions combined.** In a center where the functions of the center director and the on-site supervisor are accomplished by the same person, the educational and experience requirements for a center director shall apply. If the center director is serving in the role of the on-site supervisor, the director shall be on site daily either during the hours of operation or a minimum of at least eight hours of the center's hours of operation. If the staff person designated as the on-site supervisor is temporarily absent from the center, another responsible adult staff shall be designated as the interim on-site supervisor.

**109.6(4) Transition period for staff.** In achieving the qualifications outlined in rule 441—109.6(237A), staff hired prior to April 1, 1998, shall obtain the education, experience or child-developmental training sufficient to meet the required point totals by April 1, 1999.

**109.6(5) Volunteers and substitutes.** A volunteer shall be at least 16 years of age. All volunteers and substitutes shall:

*a.* Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

*b.* Sign a statement indicating the volunteer or substitute has been informed of the volunteer's or substitute's responsibilities as a mandatory reporter.

*c.* Undergo the record check process when any of the following criteria are met:

(1) The volunteer or substitute is included in meeting the required child-to-staff ratio;

(2) The volunteer or substitute has direct responsibility for a child or children; or

(3) The volunteer or substitute has access to a child or children with no other staff present.

*d.* Have on file at the facility a record containing the statements required in paragraphs 109.6(5) "a" and "b" and documentation of any record check process. The record shall be maintained as required in paragraph 109.9(1) "b."

**109.6(6) Record checks.**

*a. Applicability.*

(1) Criminal and child abuse record checks shall be conducted for:

1. Each owner, director, staff member, substitute, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

2. Anyone living in the child care facility who is 14 years of age or older.

(2) Parents, guardians, and custodians are exempt from the record check process in relation to access to their own children or wards.

(3) Professional staff who hold a current, valid license issued by the educational examiners board are exempt from the record check process in relation to children in the center to whom they provide professional services consistent with Iowa Code chapter 272 and rules adopted by the educational examiners board.

*b. Authorization.* A requesting entity shall request a record check evaluation prior to the employment of a person subject to record checks. The person subject to record checks shall complete the DHS criminal history record check form and any other forms required by the department of public safety to authorize the release of records.

*c. Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, shall be completed before the person's involvement with child care at the center. Iowa records checks shall be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center shall send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph (1), the department shall conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. When the department conducts the records check, the fee shall be \$25 for each record check through June 30, 2010, and \$35 effective July 1, 2010. The center shall submit the fee before the department initiates the record check process. Payment must be in the form of cash, check, money order, or cashier's check. The department may access SING to conduct the records check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

(3) Centers that participate in student intern programs may seek a waiver for substitution of the state record check process with a check performed by the student's educational institution. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

*d. National criminal history checks.* National criminal history checks based on fingerprints are required for all persons subject to record checks under this subrule effective with a center's initial licensure or relicensure on or after June 1, 2010. The national criminal history check shall be repeated for each person every four years and when the department or center becomes aware of any new

transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks. Fingerprints may be taken by law enforcement agencies, by agencies or companies that specialize in taking fingerprints, or by center staff or subcontractors who have received appropriate training in the taking of fingerprints.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center shall provide fingerprints to the department of public safety no later than 30 days after the subject's approval for employment at the center. The center shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(5) Centers that participate in student intern programs may seek a waiver to substitute the fingerprint-based check of the FBI national criminal database performed by the student's educational institution for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(6) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide the following information in writing upon a center's request, using Form 470-4896, National Criminal History Check Confirmation:

1. Date of most recent national criminal history check conducted by the center on the person in question, and

2. Whether or not the national check process resulted in clearance of the person for involvement with child care.

(7) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, shall send a copy of the results to the department for evaluation. The department shall determine whether or not the person may be involved with child care.

(8) A center shall submit all required fingerprints to the department of public safety before the issuance or renewal of the center's license on or after June 1, 2010. EXCEPTION: Centers that have an initial or renewal licensure date of June 1, 2010, shall have until July 1, 2010, to submit the fingerprints to the department of public safety.

*e. Mandatory prohibition.* A person with the following convictions or founded abuse reports is prohibited from involvement with child care:

- (1) Founded child or dependent adult abuse that was determined to be sexual abuse.

- (2) Placement on the sex offender registry.

- (3) Felony child endangerment or neglect or abandonment of a dependent person.

- (4) Felony domestic abuse.

- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.

- (6) Forcible felony.

*f. Mandatory time-limited prohibition.*

(1) A person with the following convictions or founded abuse reports is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.

2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period imposed pursuant to 109.6(6)"f"(1), the person may request the department to perform an evaluation under paragraph 109.6(6)"g" to determine whether prohibition of the person's involvement with child care continues to be warranted.

*g. Evaluation required.* For all other transgressions, and as requested under subparagraph 109.6(6) “f”(2), the department shall notify the requesting entity that an evaluation shall be conducted to determine whether prohibition of the person’s involvement with child care is warranted.

(1) The person with the transgression shall complete the record check evaluation form. The requesting entity shall provide the form and any other documents to the department within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and the requesting entity to return this form by the specified date shall result in denial or revocation of the license or denial of employment. The department shall not process evaluations that are not signed by the person subject to an evaluation.

(2) The department may use information from the department’s case records in performing the evaluation.

(3) The requesting entity may provide, or the department may request from the person subject to an evaluation or from the requesting entity, information to assist in performance of the evaluation that includes, but is not limited to, the following:

1. Documentation of criminal justice proceedings.
2. Documentation of rehabilitation.
3. Written employment references or applications.
4. Documentation of substance abuse education or treatment.
5. Criminal history records, child abuse information, and dependent adult abuse information from other states.
6. Documentation of the person’s prior residences.

(4) Any person or agency that might have pertinent information regarding criminal or abuse history and rehabilitation of the prospective employee may be contacted.

(5) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(6) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person’s involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department’s previous evaluation. The exemption is subject to all of the following conditions:

1. The person’s position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.
2. Any restrictions placed on the person’s employment by the department in the previous evaluation shall remain applicable in the person’s subsequent employment.
3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides to the subsequent employer the previous evaluation from the person’s personnel file pursuant to the person’s authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

*h. Evaluation decision.* Within 30 days of receipt of a completed record check evaluation, the department shall make a decision on the person’s involvement with child care. The department has final authority in determining whether prohibition of the person’s involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department shall mail to the requesting entity and the person on whom the evaluation was completed the record check decision that explains the decision reached regarding the evaluation of the transgression.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department shall send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter shall inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

*i. Notice to parents.* The administrator of the department shall notify the parents, guardians, and legal custodians of each child for whom the person provides child care if there has been founded child abuse committed by an owner, director, or staff member of the child care center. The center shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

**109.6(7) Use of controlled substances and medications.** All owners, personnel, and volunteers shall be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 9441B, IAB 4/6/11, effective 6/1/11; ARC 0418C, IAB 10/31/12, effective 1/1/13; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 1809C, IAB 1/7/15, effective 3/1/15]

**441—109.7(237A) Professional growth and development.** The center director, on-site supervisor, and staff counted as part of the staff ratio shall meet the following minimum staff training requirements:

**109.7(1) Required training within the first six months of employment.** During their first six months of employment, all staff shall receive the following training:

- a. Two hours of Iowa's training for mandatory reporting of child abuse.
- b. At least one hour of training regarding universal precautions and infectious disease control.

**109.7(2) Center directors and staff employed 20 hours or more per week.** The requirements of this subrule apply to all center directors, regardless of whether the director works on a full-time or part-time basis.

a. During their first year of employment, all center directors and all staff employed 20 hours or more per week shall receive the following training:

(1) Certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

(2) Certification in infant, child, and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

- (3) Ten contact hours of training from one or more of the following content areas:
1. Planning a safe, healthy learning environment (includes nutrition).
  2. Steps to advance children's physical and intellectual development.
  3. Positive ways to support children's social and emotional development (includes guidance and discipline).
  4. Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
  5. Strategies to manage an effective program operation (includes business practices).

6. Maintaining a commitment to professionalism.
7. Observing and recording children's behavior.
8. Principles of child growth and development.

(4) At least four hours of the ten contact hours of training shall be received in a group setting as defined in subrule 109.7(7). Six hours may be received in self-study using a training package approved by the department as defined in subrule 109.7(8). Training received for cardiopulmonary resuscitation (CPR), first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(5) Center directors and on-site supervisors shall receive all ten hours of training in a group setting as defined in subrule 109.7(7).

(6) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the first year's ten contact hours of training waived.

*b.* Following their first year of employment, all center directors and all staff who are employed 20 hours or more a week shall:

(1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.

(2) Receive six contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2)"a"(3). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(3) Center directors and on-site supervisors shall receive eight contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2)"a"(3). At least four of the eight contact hours shall be in a group setting as defined in subrule 109.7(7).

**109.7(3) Staff employed less than 20 hours per week.**

*a.* During their first year of employment, all staff who are employed less than 20 hours a week shall receive the following training:

(1) Five contact hours of training from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence.

(2) At least two of the five contact hours shall be in a sponsored group setting.

(3) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the five contact hours required in the first year waived.

*b.* Following their first year of employment, all staff who are employed less than 20 hours a week shall:

(1) Maintain current certification for Iowa's training for mandatory reporting of child abuse.

(2) Receive four contact hours of training annually from one or more of the following topical areas: child development, guidance and discipline, developmentally appropriate practices, nutrition, health and safety, communication skills, professionalism, business practices, and cross-cultural competence. At least two of the four contact hours shall be in a sponsored group setting.

**109.7(4) Staff employed in centers that operate summer-only programs.** Staff who are employed in centers that operate only in the summer months when school is not in session shall receive the following training:

*a.* Two hours of Iowa's training for mandatory reporting of child abuse.

*b.* At least one hour of training regarding universal precautions and infectious disease control.

*c.* At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall have certification in American Red Cross or American Heart Association infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

*d.* At least one staff person on duty in the center and outdoor play area when children are present and on field trips shall receive certification in infant, child and adult first aid that uses a nationally

recognized curriculum or is received from a nationally recognized training organization including the American Red Cross, American Heart Association, the National Safety Council, and Emergency Medical Planning (Medic First Aid) or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

**109.7(5) *Training plans.*** Training shall supplement educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served.

**109.7(6) *Substitution.*** A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

**109.7(7) *Group training.*** Training received in a group setting is not self-study, but is training received with other adults, either in or out of the child care center.

*a.* The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
- (2) A community college.
- (3) Iowa State University Extension.
- (4) A child care resource and referral agency.
- (5) An area education agency.
- (6) The regents' center for early developmental education at the University of Northern Iowa.
- (7) A hospital (for health and safety, first-aid, and CPR training).
- (8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).
- (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
- (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
- (11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- (12) The Iowa department of public health, department of education, or department of human services.
- (13) Head Start agencies or the Head Start technical assistance system.

*b.* Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph "a" or an entity approved under paragraph "g." Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

*c.* Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 109.7(9);
- (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and
- (3) The training organization meets the requirements listed in this subrule or is approved by the department.

*d.* The department will not approve more than eight hours of training delivered in a single day.

*e.* The department may randomly monitor any state-approved training for quality control purposes.

*f.* Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

*g.* A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

**109.7(8) Self-study training.**

*a.* Self-study training packages approved by the department include curriculum developed and materials distributed by:

- (1) Department child care licensing consultants,
- (2) Iowa State University Extension, or
- (3) A child care resource and referral agency.

*b.* Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

**109.7(9) Approved training.** Training provided to Iowa child care providers shall offer:

*a.* Instruction that is consistent with:

- (1) Iowa child care regulatory standards;
- (2) The Iowa early learning standards; and
- (3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

*b.* Content equal to at least one contact hour of training.

*c.* An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

*d.* A certificate of training for each participant that includes:

- (1) The name of the participant.
- (2) The title of the training.
- (3) The dates of training.
- (4) The content area addressed.
- (5) The name of the training organization.
- (6) The name of the instructor.
- (7) The number of contact hours.
- (8) An indication of whether the training was delivered through self-study or in a group setting.

[ARC 8650B, IAB 4/7/10, effective 6/1/10]

**441—109.8(237A) Staff ratio requirements.**

**109.8(1) Staff requirements.** Persons counted as part of the staff ratio shall meet the following requirements:

*a.* Be at least 16 years of age. If less than 18 years of age, the staff shall be under the direct supervision of an adult.

*b.* Be involved with children in programming activities.

*c.* At least one staff person on duty in the center and outdoor play area when children are present and present on field trips shall be over the age of 18 and hold current certification in first aid and cardiopulmonary resuscitation (CPR) as required in rule 441—109.7(237A).

**109.8(2) Staff ratio.** The staff-to-child ratio shall be as follows:

<u>Age of children</u>	<u>Minimum ratio of staff to children</u>
Two weeks to two years	One to every four children
Two years	One to every six children
Three years	One to every eight children
Four years	One to every twelve children
Five years to ten years	One to every fifteen children
Ten years and over	One to every twenty children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group. If children three years of age and under are included in the combined age group, the staff ratio for children aged three and under shall be maintained for these children. Preschools shall have staff ratios determined on the age of the majority of the children, including children who are three years of age.

b. If a child between the ages of 18 and 24 months is placed outside the infant area, as defined at subrule 109.11(2), the staff ratio of 1 to 4 shall be maintained as would otherwise be required for the group until the child reaches the age of two.

c. Every child-occupied program room shall have adult supervision present in the room.

d. During nap time, at least one staff shall be present in every room where children are resting. Staff ratio requirements may be reduced to one staff per room where children are resting for a period of time not to exceed one hour provided staff ratio coverage can be maintained in the center. The staff ratio shall always be maintained in the infant area.

e. The minimum staff ratio shall be maintained at mealtimes and for any outdoor activities at the center.

f. When seven or more children over the age of three are present on the licensed premises or are being transported in one vehicle, at least two adult staff shall be present. Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school. When a center contracts with another entity to provide transportation other than for the purpose of transporting school-age children to or from school, at least one adult staff in addition to the driver shall be present if at least seven children provided care by the center are transported.

g. Any child care center-sponsored program activity involving five or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children.

h. For a period of two hours or less at the beginning or end of the center's hours of operation, one staff may care for six children or less, provided no more than two of the children are under the age of two years.

i. For centers or preschools serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

#### **441—109.9(237A) Records.**

**109.9(1) Personnel records.** The center shall maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file shall contain, at a minimum, the following:

a. A statement signed by each individual indicating whether or not the individual has any conviction of violating any law in any state or has any record of founded child abuse or dependent adult abuse in any state.

b. Copies of all records checks kept in accordance with state and federal law regarding confidentiality of records checks. These records shall include:

(1) A copy of Form 595-1396, DHS Criminal History Record Check Form B, or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of Form 470-0643, Request for Child Abuse Information, when applicable.

(3) Copies of the results of Iowa records checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a records check, regardless of findings.

c. Reserved.

d. A physical examination report. Personnel shall have good health as evidenced by a preemployment physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to beginning employment by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

e. Documentation showing the minimum staff training requirements as outlined at rule 441—109.7(237A) are met, including current certifications in first aid and cardiopulmonary resuscitation (CPR) and Iowa's training for the mandatory reporting of child abuse.

f. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

**109.9(2) *Child's file.*** Centers shall maintain sufficient information in a file for each child, which shall be updated at least annually or when the parent notifies the center of a change or the center becomes aware of a change, to ensure that:

a. A parent or an emergency contact authorized by the parent can be contacted at any time the child is in the care of the center.

b. Appropriate emergency medical and dental services can be secured for the child while in the center's care.

c. Information is available in the center regarding the specific health and medical needs of a child, including information regarding any professionally prescribed treatment. Information shall include a physical examination report as required at subrule 109.10(1). For a center serving school-age children that operates in the same school facility in which the child attends school, documentation shall include a statement signed by the parent that the immunization information is available in the school file.

d. A child is released only to authorized persons.

e. Documentation of injuries, accidents, or other incidents involving the child is maintained.

f. Parent authorization is obtained for a child to attend center-sponsored field trips and non-center activities. If parental authorization is obtained on an authorization form inclusive of all children participating in the activity, the authorization form shall be kept on file at the center.

**109.9(3) *Immunization certificates.*** Signed and dated Iowa immunization certificates, provided by the state department of public health, shall be on file for each child enrolled as prescribed by the department of public health at 641—Chapter 7.

**109.9(4) *Daily activities.*** For each child under two years of age, the center shall make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

a. The time periods in which the child has slept.

b. The amount of food consumed and the times at which the child has eaten.

c. The time of and any irregularities in the child's elimination patterns.

d. The general disposition of the child.

e. A general summary of the activities in which the child participated.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 0996C, IAB 9/4/13, effective 11/1/13]

**441—109.10(237A) Health and safety policies.** The child care center shall establish definite health policies, including the criteria for excluding a sick child from the center. The policies shall be consistent with the recommendations of the National Health and Safety Performance Standards and shall include, but are not limited to:

**109.10(1) Physical examination report.**

*a. Preschool-age children.* For each child five years of age and younger not enrolled in kindergarten, the child care center shall require an admission physical examination report, submitted within 30 days from the date of admission, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner. The date of the physical examination shall be no more than 12 months prior to the first day of attendance at the center. The written report shall include past health history, status of present health including allergies, medications, and acute or chronic conditions, and recommendations for continued care when necessary. Annually thereafter, a statement of health condition, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner, shall be submitted that includes any change in functioning, allergies, medications, or acute or chronic conditions.

*b. School-age children.* For each child five years of age and older and enrolled in school, the child care center shall require, prior to admission, a statement of health status signed by the parent or legal guardian that certifies that the child is free of communicable disease and that specifies any allergies, medications, or acute or chronic conditions. The statement from the parent shall be submitted annually thereafter.

*c. Religious exemption.* Nothing in this rule shall be construed to require medical treatment or immunization for staff or the child of any person who is a member of a church or religious organization which has guidelines governing medical treatment for disease that are contrary to these rules. In these instances, an official statement from the organization shall be incorporated in the personnel or child's file.

**109.10(2) Medical and dental emergencies.** The center shall have sufficient information and authorization to meet the medical and dental emergencies of children. The center shall have written procedures for medical and dental emergencies and shall ensure, through orientation and training, that all staff are knowledgeable of and able to implement the procedures.

**109.10(3) Medications.** The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications, including the following:

*a.* All medications shall be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so they are inaccessible to children and the public. Nonprescription medications shall be labeled with the child's name.

*b.* For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.

*c.* In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

**109.10(4) Daily contact.** Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior which may adversely affect the child or the group. The center shall post notice at the main entrance to the center where it is visible to parents and the public of exposure of a child receiving care by the center to a communicable disease, the symptoms, and the period of communicability. If the center is located in a building used for other purposes and shares the main entrance to the building, the notice shall be conspicuously posted in the center in an area that is frequented daily by parents or the public.

**109.10(5) Infectious disease control.** Centers shall establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

**109.10(6) *Quiet area for ill or injured.*** The center shall provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person shall be notified of the child's status in the event of a serious illness or emergency.

**109.10(7) *Staff hand washing.*** The center shall ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease. All staff shall wash their hands at the following times:

- a. Upon arrival at the center.
- b. Immediately before eating or participating in any food service activity.
- c. After diapering a child.
- d. Before leaving the rest room either with a child or by themselves.
- e. Before and after administering nonemergency first aid to a child if gloves are not worn.
- f. After handling animals and cleaning cages.

**109.10(8) *Children's hand washing.*** The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing and one for rinsing may be used in place of running water. Children's hands shall be washed at the following times:

- a. Immediately before eating or participating in any food service activity.
- b. After using the rest room or being diapered.
- c. After handling animals.

**109.10(9) *First-aid kit.*** The center shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

**109.10(10) *Recording incidents.*** Incidents involving a child, including minor injuries, minor changes in health status, or other minor behavioral concerns, shall be reported to the parents, guardians, and legal custodians on the day of the incident. Incidents resulting in an injury to a child shall be reported to the parent on the day of the incident. Incidents resulting in a serious injury to a child or incidents resulting in a significant change in the health status of a child shall be verbally reported to the parents, guardians, and legal custodians immediately. The parents, guardians, and legal custodians of any child included in incidents involving inappropriate, sexually acting-out behavior shall be notified immediately after the incident. A written report, fully documenting every incident, shall be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident and a copy shall be retained in the child's file.

**109.10(11) *Smoking.*** Smoking and the use of tobacco products shall be prohibited at all times in the center and in every vehicle used to transport children. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during hours of operation of the center. Nonsmoking signs shall be posted at every entrance of the child care center and in every vehicle used to transport children. All signs shall include:

- a. The telephone number for reporting complaints, and
- b. The Internet address of the department of public health ([www.iowasmokefreeair.gov](http://www.iowasmokefreeair.gov)).

**109.10(12) *Transportation.*** As outlined in Iowa Code section 321.446, all children transported in a motor vehicle subject to registration, except a bus, shall be individually secured by a safety belt, safety seat, or harness in accordance with federal motor vehicle safety standards and the manufacturer's instructions.

a. Children under the age of 6 shall be secured during transit in a federally approved child restraint system. Children under 1 year of age and weighing less than 20 pounds shall be secured during transit in a rear-facing child restraint system.

b. Children under the age of 12 shall not be located in the front seating section of the vehicle.

c. Drivers of vehicles shall possess a valid driver's license and shall not operate a vehicle while under the influence of alcohol, illegal drugs, prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.

*d.* Vehicles that are owned or leased by the center shall receive regular maintenance and inspection according to manufacturer-recommended guidelines for vehicle and tire maintenance and inspection.

**109.10(13) *Field trip emergency numbers.*** Emergency telephone numbers for each child shall be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

**109.10(14) *Pets.*** Animals kept on site shall be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets, reptiles, including turtles, or birds of the parrot family shall be kept on site. Pets shall not be allowed in kitchen or food preparation areas.

**109.10(15) *Emergency plans.***

*a.* The center shall have written emergency plans for responding to fire, tornado, flood (if area is susceptible to flood), intruders within the center, intoxicated parents and lost or abducted children. In addition, the center shall have guidelines for responding or evacuating in case of blizzards, power failures, bomb threats, chemical spills, earthquakes, or other disasters that could create structural damage to the center or pose health hazards. If the center is located within a ten-mile radius of a nuclear power plant or research facility, the center shall also have plans for nuclear evacuations. Emergency plans shall include written procedures including plans for transporting children and notifying parents, emergency telephone numbers, diagrams, and specific considerations for immobile children.

*b.* Emergency instructions, telephone numbers, and diagrams for fire, tornado, and flood (if area is susceptible to floods) shall be visibly posted by all program and outdoor exits. Emergency plan procedures shall be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills shall be maintained for the current and previous year.

*c.* The center shall develop procedures for annual staff training on these emergency plans and shall include information on responding to fire, tornadoes, intruders, intoxicated parents and lost or abducted children in the orientation provided to new employees.

*d.* The center shall conduct a daily check to ensure that all exits are unobstructed.

**109.10(16) *Supervision and access.***

*a.* The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.

*b.* Any person in the center who is not an owner, staff member, substitute, or volunteer who has a record check and department approval to be involved with child care shall not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

*c.* Persons who are exempt from the record check process are granted access in accordance with 109.6(6)“*a*”(2) unless the provisions of paragraph 109.10(16)“*d*” apply.

*d.* A sex offender who has been convicted of a sex offense against a minor and who is required to register with the Iowa sex offender registry under the provisions contained in Iowa Code chapter 692A shall not operate, manage, be employed by, or act as a contractor or volunteer at a child care center. The sex offender also shall not be present upon the property of a child care center without the written permission of the center director, except for the time reasonably necessary to transport the offender’s own minor child or ward to and from the center.

(1) Written permission shall include the conditions under which the sex offender may be present, including:

1. The precise location in the center where the sex offender may be present;
2. The reason for the sex offender’s presence at the facility;
3. The duration of the sex offender’s presence;
4. Description of the supervision that the center staff will provide the sex offender to ensure that no child is alone with the sex offender.

(2) Before giving written permission, the center director shall consult with the center licensing consultant. The written permission shall be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14]

**441—109.11(237A) Physical facilities.**

**109.11(1) Room size.** The program room size shall be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there shall be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children shall not be used as regular program space or counted as useable floor space.

**109.11(2) Infants' area.** An area shall be provided properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older. Children over 18 months of age may be grouped outside this area if appropriate to the developmental needs of the child. Upon the recommendation of a child's physician or the area education agency serving the child, a child who is two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

**109.11(3) Facility requirements.**

*a.* The center shall ensure that:

- (1) The facility and premises are sanitary, safe and hazard-free.
- (2) Adequate indoor and outdoor program space that is adjacent to the center is provided. Centers shall have a safe outdoor program area with at least sufficient square footage to accommodate 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area shall include safe play equipment and an area of shade.
- (3) Sufficient program space is provided for dining to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures.
- (4) Sufficient lighting shall be provided to allow children to adequately perform developmental tasks without eye strain.
- (5) Sufficient ventilation is provided to maintain adequate indoor air quality.
- (6) Sufficient heating is provided to allow children to perform tasks comfortably without excessive clothing.
- (7) Sufficient cooling is provided to allow children to perform tasks without being excessively warm or subject to heat exposure.
- (8) Sufficient bathroom and diapering facilities are provided to attend immediately to children's toileting needs and maintained to reduce the transmission of disease.
- (9) Equipment, including kitchen appliances, placed in a program area is maintained so as not to result in burns, shock or injury to children.
- (10) Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

*b.* Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

*c.* Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

*d.* The director or designated person shall complete and keep a record of at least monthly inspections of the outdoor recreation area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and shall complete and document an inspection prior to resuming use of the area.

*e.* Centers that operate in a public school building, including before and after school programs and summer programs serving school-age children, may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building. Centers shall ensure that the space occupied by the center is sanitary, safe, and hazard-free and shall conduct monthly playground inspections or provide documentation that one has been completed by the public school personnel.

**109.11(4) Bathroom facilities.** At least one functioning toilet and one sink for each 15 children shall be provided in a room with natural or artificial ventilation. Training seats or chairs may be used for children under two years of age. New construction after November 1, 1995, shall provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink shall be provided in program rooms for infants and toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

**109.11(5) Telephone.** A working nonpay telephone shall be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison information center posted adjacent to the telephone. The street address and telephone number of the center shall be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained near the telephone.

**109.11(6) Kitchen appliances and microwaves.** Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area shall be sectioned off and shall not be counted as useable floor space for room size. Centers using microwave ovens for warming infant bottles or infant food shall ensure that the formula or food item is not served immediately to the child after being removed from the microwave. The infant bottle shall be shaken or food stirred and the formula or food item tested by the caregiver before being fed to the infant. Breast milk shall not be warmed in a microwave.

**109.11(7) Environmental hazards.**

*a.* Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that it is not lead-based paint. If the presence of peeling or chipping paint is found, interim controls using safe work methods as defined by the state department of public health shall be accomplished prior to a full license being issued.

*b.* Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing performed as prescribed by the state department of public health at 641—Chapter 43. Testing shall be required if test kits are available from the local health department or the Iowa Radon Coalition. Retesting shall be accomplished at least every two years from the date of the initial measurement if test kits are available from the local health department or the Iowa Radon Coalition. If testing determines confirmed radon gas levels in excess of 4.0 picocurie per liter, a plan using radon mitigation procedures established by the state department of public health shall be developed with and approved by the state department of public health prior to a full license being issued.

*c.* To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis prior to the heating season, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034.

*d.* Centers that operate before and after school programs and summer-only programs that serve only school-age children and that operate in a public school building are exempted from testing for lead, radon, and carbon monoxide.

**441—109.12(237A) Activity program requirements.**

**109.12(1) Activities.** The center shall have a written curriculum or program structure that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

- a. A curriculum or program of activities that promotes self-esteem and positive self-image; social interaction; self-expression and communication skills; creative expression; and problem-solving skills.
- b. A balance of active and quiet activities; individual and group activities; indoor and outdoor activities; and staff-initiated and child-initiated activities.
- c. Activities which promote both gross and fine motor development.
- d. Experiences in harmony with the ethnic and cultural backgrounds of the children.
- e. A supervised nap or quiet time for all children under the age of six not enrolled in school who are present at the center for five or more hours.

**109.12(2) Discipline.** The center shall have a written policy on the discipline of children which provides for positive guidance, with direction for resolving conflict and the setting of well-defined limits. The written policy shall be provided to staff at the start of employment and to parents at time of admission. The center shall not use as a form of discipline:

- a. Corporal punishment including spanking, shaking, and slapping.
- b. Punishment which is humiliating or frightening or which causes pain or discomfort to the child. Children shall never be locked in a room, closet, box or other device. Mechanical restraints shall never be used as a form of discipline. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.
- c. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.
- d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

**109.12(3) Policies for children requiring special accommodations.** Reasonable accommodations, based on the special needs of the child, shall be made in providing care to a child with a disability. Accommodation can be a specific treatment prescribed by a professional or a parent, or a modification of equipment, or removal of physical barriers. The accommodation shall be recorded in the child's file.

**109.12(4) Play equipment, materials and furniture.** The center shall provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products. Play equipment, materials, and furniture shall meet the developmental, activity, and special needs of the children.

Rooms shall be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding shall be provided for all children who nap. The center shall develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing shall be maintained between equipment to reduce the transmission of disease, to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures. The center shall provide sufficient toilet articles for each child for hand washing. Parents may provide items for oral hygiene (if appropriate to the developmental age and needs of the child). The center shall ensure that sanitary procedures are followed for use and storage of the articles.

**109.12(5) Infant environment.** A child care center serving children two weeks to two years old must provide an environment which protects the children from physical harm, but is not so restrictive as to inhibit physical, intellectual, emotional, and social development.

- a. Stimulation shall be provided to each child through being held, rocked, played with and talked with throughout the time care is provided. Insofar as possible, the same adult should provide complete care for the same child.

b. Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

c. Highchairs or hook-on seats shall be equipped with a safety strap which shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

d. Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

e. Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized by a parent or physician. A crib or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or criblike furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or criblike furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

f. When playpens are provided, no more than one child shall be placed in one at any time.

g. Infant walkers shall not be used.

h. For programs operating five hours or less on a daily basis, the center shall have a sufficient number of cribs or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products for children who may nap during the time in attendance. Cribs or criblike furniture shall be used by only one child at a time and shall be maintained in a clean and sanitary manner.

**441—109.13(237A) Extended evening care.** A center providing extended evening care shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

**109.13(1) Facility requirements.**

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene which the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

**109.13(2) Activities.**

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

**441—109.14(237A) Get-well center.** A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

**109.14(1) Staff requirements.**

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in state board of nursing rules at 655—6.1(152).

**109.14(2) Health policies.**

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards, approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the state department of public health.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

(1) Admitting symptoms.

(2) Medications administered and time they were administered.

(3) Nutritional intake.

(4) Rest periods.

(5) Output.

(6) Temperature.

**109.14(3) Exceptions.** The following exceptions to 441—Chapter 109 shall be applied to get-well centers:

a. A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over the age of two.

b. All staff that have contact with children shall have a minimum of 17 clock hours of special training in caring for mildly ill children. Current certification of the training shall be contained in the personnel files. Special training shall be department-approved and include the following:

(1) Four hours' training in infant and child cardiopulmonary resuscitation (CPR), four hours' training in pediatric first aid, and one hour of training in infection control within the first month of employment.

(2) Six hours' training in care of ill children, and two hours' training in child abuse identification and reporting within the first six months of employment and every five years thereafter.

c. There shall be 40 square feet of program space per child.

d. There shall be a sink with hot and cold running water in every child-occupied room.

e. Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

f. Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age, and shall be in separate rooms with full walls and doors.

**441—109.15(237A) Food services.** Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

**109.15(1) Nutritionally balanced meals or snacks.** The center shall serve each child a full, nutritionally balanced meal or snack as defined by the USDA Child and Adult Care Food Program (CACFP) guidelines and shall ensure that staff provide supervision at the table during snacks and meals.

Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

**109.15(2) Menu planning.** The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years. Menus shall be planned at least one week in advance, made available to parents, and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of causing choking in young children shall be avoided or modified. Provisions of this subrule notwithstanding, exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

**109.15(3) Feeding of children under two years of age.**

*a.* All children under 12 months of age shall be fed on demand, unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns. Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Menu patterns may be modified according to written instructions from the parent, physician or health care provider. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

*b.* All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall not be placed in a crib with a bottle or left sleeping with a bottle. Spoon feeding shall be adapted to the developmental capabilities of the child.

*c.* Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

*d.* Whole milk for children under age two who are not on formula or breast milk unless otherwise directed by a physician.

*e.* Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

**109.15(4) Food brought from home.**

*a.* The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines are maintained.

*b.* The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

*c.* Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

*d.* Snacks that may not meet CACFP nutrition guidelines may be provided by parents for special occasions such as birthdays or holidays.

**109.15(5) Food preparation, storage, and sanitation.** Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the National Health and Safety Performance Standards and provide:

*a.* Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

*b.* Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

*c.* Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

*d.* Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

**109.15(6) Water supply.** The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

a. Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

b. When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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CHAPTER 110  
CHILD DEVELOPMENT HOMES

[Prior to 7/1/83, Social Services[770] Ch 110]

[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes registration procedures for child development homes. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigation.

**441—110.1(237A) Definitions.**

*“Adult”* means a person aged 18 or older.

*“Assistant”* means a responsible person aged 14 or older. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

*“Child”* means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

*“Child care”* means the care, supervision, or guidance of a child by a person other than the child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. Child care shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

*“Child care facility”* or *“facility”* means a child care center, a preschool, or a registered child development home.

*“Child care home”* means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

*“Child development home”* means a person or program registered under this chapter that may provide child care to six or more children at any one time.

*“Department”* means the department of human services.

*“Involvement with child care”* means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

*“Parent”* means parent or legal guardian.

*“Part-time hours”* means the hours that child development homes in categories B and C are allowed to exceed their maximum preschool or school-age capacity. A provider may use a total of up to 180 hours per month as part-time hours. No more than two children using part-time hours may be in the child development home at any one time.

*“Person subject to an evaluation”* means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for registration or is registered.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

*“Provider”* means the person or program that applies for registration to provide child care and is approved as a child development home.

“*Registration*” means the process by which child care providers certify that they comply with rules adopted by the department.

“*Registration certificate*” means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

“*School*” means kindergarten or a higher grade level.

“*Transgression*” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

**441—110.2(237A) Application for registration.** A provider shall apply for registration on Form 470-3384, Application for Child Development Home Registration, provided by the department’s local office or, if available, on the department’s Web site. The provider shall also use Form 470-3384 to inform the department of any changes in circumstances that would affect the registration.

**441—110.3(237A) Renewal.** Renewal of registration shall be completed every 24 months. To request renewal, a provider shall submit Form 470-3384, Application for Child Development Home Registration, and copies of certificates of training, to be retained in the registration file. The renewal process shall include completion of child abuse, sex offender, and criminal record checks.

**441—110.4(237A) Number of children.** The number of children shall conform to the following standards:

**110.4(1) Limit.** Except as provided in subrule 110.4(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

**110.4(2) Children counted.** In determining the number of children cared for at any one time in a child development home, each child present in the child development home shall be considered to be receiving care unless the child is described by one of the following exceptions:

*a.* The child’s parent, guardian, or custodian established or operates the child development home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

*b.* The child has been present in the child development home for more than 72 consecutive hours and meets the requirements of the exception in paragraph “*a*” as though the person who established or operates the child development home is the child’s parent, guardian, or custodian.

**110.4(3) Exception for emergency school closing.** On days when schools are closed due to emergencies such as inclement weather or physical plant failure, a child development home may have additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

*a.* The child development home has prior written approval from the parent or guardian of each child present in the home concerning the presence of additional children in the home.

*b.* The child development home has a department-approved assistant, aged 14 or older, on duty to assist the care provider, as required for the registration category of the home.

*c.* One or more of the following conditions are applicable to each of the additional children present in the child development home:

- (1) The home provides care to the child on a regular basis for periods of less than two hours.
- (2) If the child were not present in the child development home, the child would be unattended.
- (3) The home regularly provides care to a sibling of the child.

*d.* The provider shall maintain a written record including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

**441—110.5(237A) Standards.** The provider shall certify that the child development home meets the following standards and also the standards in either rule 441—110.8(237A), 441—110.9(237A), or 441—110.10(237A), specific to the category of home for which the provider requests registration.

**110.5(1) Health and safety.** Conditions in the home shall be safe, sanitary, and free of hazards.

*a.* The home shall have a non-pay, working telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be written on paper and readily accessible by the telephone. The home must prominently display all emergency information, and a paper copy of emergency parent contact information must be kept in all travel vehicles. If the working telephone is a mobile telephone, all emergency numbers must also be programmed and saved into the telephone.

*b.* All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

*c.* A first-aid kit shall be available and easily accessible whenever children are in the child development home, in the outdoor play area, in vehicles used to transport children, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

*d.* Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children.

*e.* Electrical wiring shall be maintained with all accessible electrical outlets safely capped and electrical cords properly used. Improper use includes running cords under rugs, over hooks, through door openings, or other use that has been known to be hazardous.

*f.* Combustible materials shall be kept away from furnaces, stoves, water heaters, and gas dryers.

*g.* Approved safety gates at stairways and doors shall be provided and used as needed.

*h.* A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child, and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by drainage or ponding of sewage, household waste, or storm water.

*i.* Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

*j.* Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

*k.* Fire and tornado drills shall be practiced monthly and the provider shall keep documentation evidencing compliance with monthly practice on file.

*l.* A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

*m.* The home shall have at least one 2A 10BC rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

*n.* The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed

according to manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

*o.* Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. Nonsmoking signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

- (1) The telephone number for reporting complaints, and
- (2) The Internet address of the department of public health ([www.iowasmokefreeair.gov](http://www.iowasmokefreeair.gov)).

*p.* Children under the age of one year shall be placed on their backs when sleeping unless otherwise authorized in writing by a physician.

*q.* Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that it is free of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

*r.* When there is a swimming or wading pool on the premises:

(1) A wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the standards of the American Society for Testing and Materials.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is four feet above the side walls.

(4) An uncovered in-ground swimming pool shall be enclosed with a fence that is at least four feet high and flush with the ground.

*s.* If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

*t.* Homes served by private sewer systems shall be compliant with environmental protection commission rules on wastewater treatment and disposal systems at 567—Chapter 69. Compliance shall be verified by the local board of health within 12 months of renewal or new registration.

*u.* The provider shall have written policies regarding the care of mildly ill children and exclusion of children due to illness and shall inform parents of these policies.

*v.* The provider shall have written policy and procedures for responding to health-related emergencies.

w. The provider shall document all injuries that require first aid or medical care using an injury report form. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

x. A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child development home registration or a renewal of the registration. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of peeling or chipping paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

EXCEPTION: Providers that have a valid registration on November 1, 2009, shall assess and control lead hazards by June 30, 2010.

**110.5(2)** Provider files. A provider file shall be maintained and shall contain the following:

a. A physical examination report. Providers and all members of a provider's household shall have good health as evidenced by a preregistration physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to registration by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

b. Certificates or other documentation from the department verifying the following:

(1) Required training as set forth in subrule 110.5(11).

(2) Completion of all record checks as required in subrule 110.7(3), at initial application, at each application for change and at each application for renewal.

c. An individual file for each staff assistant that contains:

(1) Documentation from the department confirming the record checks required under subrule 110.7(3) have been completed and authorizing or conditionally limiting the person's involvement with child care.

(2) A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.5(2) "a."

(3) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

d. An individual file for each substitute that contains:

(1) Documentation from the department confirming the record checks required under subrule 110.7(3) have been completed and authorizing or conditionally limiting the person's involvement with child care.

(2) A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.5(2) "a."

(3) Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within six months of employment and every five years thereafter, as required by Iowa Code section 232.69.

(4) Certification in first aid that meets the requirements of paragraph 110.5(11) "b."

**110.5(3)** Activity program. There shall be an activity program which promotes self-esteem and exploration and includes:

a. Active play.

b. Quiet play.

c. Activities for large muscle development.

- d.* Activities for small muscle development.
- e.* Play equipment and materials in a safe condition, for both indoor and outdoor activities which are developmentally appropriate for the ages and number of children present.

**110.5(4)** The certificate of registration shall be displayed in a conspicuous place.

**110.5(5)** Parental access. Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home, unless parental contact is prohibited by court order.

**110.5(6)** Discipline. Discipline shall conform to the following standards:

- a.* Corporal punishment including spanking, shaking and slapping shall not be used.
- b.* Punishment which is humiliating or frightening or which causes pain or discomfort to the child shall not be used.
- c.* Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.
- d.* No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.
- e.* Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

**110.5(7)** Meals. Regular meals and midmorning and midafternoon snacks shall be provided which are well-balanced, nourishing, and in appropriate amounts as defined by the USDA Child and Adult Care Food Program. Children may bring food to the child development home for their own consumption, but shall not be required to provide their own food.

**110.5(8)** Children's files. An individual file shall be maintained for each child and updated annually or when the provider becomes aware of changes. The file shall contain:

- a.* Identifying information including, at a minimum, the child's name, birth date, parent's name, address, telephone number, special needs of the child, and the parent's work address and telephone number.
- b.* Emergency information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.
- c.* A signed medical consent from the parent authorizing emergency treatment.
- d.* An admission physical examination report signed by a licensed physician or designee in a clinic supervised by a licensed physician.
  - (1) The date of the physical examination shall not be more than 12 months before the child's first day of attendance at the child development home.
  - (2) The written report shall include past health history, status of present health, allergies and restrictive conditions, and recommendations for continued care when necessary.
  - (3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.
  - (4) The examination report or statement of health status shall be on file before the child's first day of care.
- e.* A statement of health condition signed by a physician or designee submitted annually from the date of the admission physical. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.
- f.* A list signed by the parent which names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.
- g.* A signed and dated immunization certificate provided by the state department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.
- h.* For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

*i.* Written permission from the parent for the child to attend activities away from the child development home. The permission shall include:

- (1) Times of departure and arrival.
- (2) Destination.
- (3) Persons who will be responsible for the child.

*j.* Injury report forms documenting injuries requiring first aid or medical care.

**110.5(9)** Provider. The provider shall meet the following requirements:

- a.* Give careful supervision at all times.
- b.* Exchange information with the parent of each child frequently to enhance the quality of care.
- c.* Give consistent, dependable care and be capable of handling emergencies.
- d.* Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.

**110.5(10)** Substitutes. The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

- a.* All standards in this chapter regarding supervision and care of children shall apply to substitutes.
- b.* Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.

*c.* The substitute must be 18 years of age or older.

*d.* Use of a substitute shall be limited to:

- (1) No more than 25 hours per month.
- (2) An additional period of up to two weeks in a 12-month period.

*e.* The provider shall maintain a written record of the number of hours substitute care is provided, including the date and the name of the substitute.

**110.5(11)** Professional development.

*a.* The provider shall receive two hours of Iowa's training for mandatory reporting of child abuse:

- (1) During the first three months of registration as a child development home; and
- (2) Every five years thereafter.

*b.* The provider shall obtain first-aid training within the first three months of registration as a child development home.

(1) First-aid training shall be provided by a nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid) or by an equivalent trainer using curriculum approved by the department.

(2) First-aid training shall include certification in infant and child first aid that includes management of a blocked airway and mouth-to-mouth resuscitation.

(3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

*c.* During the first year of registration, the provider shall receive a minimum of 12 hours of training from one or more of the following content areas. The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12), and 2 of the hours must be from the content area in subparagraph 110.5(11)“c”(1). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(1) Planning a safe, healthy learning environment (includes nutrition).

(2) Steps to advance children's physical and intellectual development.

(3) Positive ways to support children's social and emotional development (includes guidance and discipline).

(4) Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).

(5) Strategies to manage an effective program operation (includes business practices).

- (6) Maintaining a commitment to professionalism.
- (7) Observing and recording children's behavior.
- (8) Principles of child growth and development.

*d.* During the second year of registration and each succeeding year, the provider shall receive a minimum of 12 hours of training from one or more of the content areas as defined in paragraph "c." The provider shall receive at least 6 of these hours in a group setting as defined in subrule 110.5(12). The provider may receive the remaining hours in self-study as defined in subrule 110.5(13). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

*e.* A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

**110.5(12)** Group training. Training received in a group setting is not self-study, but is training received with other adults.

*a.* The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed by or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
- (2) A community college.
- (3) Iowa State University Extension.
- (4) A child care resource and referral agency.
- (5) An area education agency.
- (6) The regents' center for early developmental education at the University of Northern Iowa.
- (7) A hospital (for health and safety, first-aid, and CPR training).
- (8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).
- (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
- (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
- (11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- (12) The Iowa department of public health, department of education, or department of human services.

(13) Head Start agencies or the Head Start technical assistance system.

*b.* Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph "a" or an entity approved under paragraph "g." Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

*c.* Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 110.5(14);
- (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and
- (3) The training organization meets the requirements listed in this subrule or is approved by the department.

*d.* The department will not approve more than eight hours of training delivered in a single day.

*e.* The department may randomly monitor any state-approved training for quality control purposes.

*f.* Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

*g.* A training organization not approved by the department may submit training for approval to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

**110.5(13)** Self-study training. Up to six hours of training may be received in self-study using a training package approved by the department.

*a.* Self-study training packages approved by the department include curriculum developed and materials distributed by:

- (1) Department child care licensing consultants,
- (2) Iowa State University Extension, or
- (3) A child care resource and referral agency.

*b.* Self-study training materials not distributed by these entities may be submitted by the training organization to the department for approval on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

**110.5(14)** Approved training. Training provided to Iowa child care providers shall offer:

*a.* Instruction that is consistent with:

- (1) Iowa child care regulatory standards;
- (2) The Iowa early learning standards; and
- (3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

*b.* Content equal to at least one contact hour of training.

*c.* An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours if training is delivered in a group setting.

*d.* A certificate of training for each participant that includes:

- (1) The name of the participant.
- (2) The title of the training.
- (3) The dates of training.
- (4) The content area addressed.
- (5) The name of the training organization.
- (6) The name of the instructor.
- (7) The number of contact hours.
- (8) An indication of whether the training was delivered through self-study or in a group setting.

[ARC 8098B, IAB 9/9/09, effective 11/1/09; ARC 0666C, IAB 4/3/13, effective 6/1/13; ARC 0996C, IAB 9/4/13, effective 11/1/13; ARC 1636C, IAB 10/1/14, effective 1/1/15; see Delay note at end of chapter]

**441—110.6(237A) Compliance checks.** During a calendar year, the department shall seek to check 100 percent of all child development homes in each county for compliance with registration requirements. Completed evaluation checklists shall be placed in the registration files.

[ARC 1637C, IAB 10/1/14, effective 1/1/15]

**441—110.7(234) Registration decision.** The department shall issue Form 470-3498, Certificate of Registration, when an applicant meets all requirements for registration. Each local office of the department shall maintain a current list of registered child development homes as a referral service to the community.

**110.7(1)** Registration shall be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also

be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

**110.7(2)** Record shall be kept in an open file of all denials or revocations of registration and the documentation of reasons for denying or revoking the registration.

**110.7(3)** Record checks.

*a. Applicability.* The department shall conduct Iowa criminal history record and child abuse record checks for each registrant, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each registrant, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Effective July 1, 2013, registration or renewal certificates shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

*b. Authorization.* The person subject to record checks shall complete the Iowa department of human services record check authorization form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; and any other forms required by the department of public safety to authorize the release of records.

*c. Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the registrant becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

*d. National criminal history record checks.* Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be effective on or after July 1, 2013, for an initial application for registration or a renewal application for registration. The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or registrant becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The registrant is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the prints to the department so the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

*e. Mandatory prohibition.* A person with any of the following convictions or founded abuse reports is prohibited from involvement with child care:

- (1) Founded child or dependent adult abuse that was determined to be sexual abuse.
- (2) Placement on the sex offender registry.
- (3) Felony child endangerment or neglect or abandonment of a dependent person.

- (4) Felony domestic abuse.
- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.
- (6) Forcible felony.

*f. Mandatory time-limited prohibition.*

(1) A person with the following conviction or founded abuse report is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.
2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 110.7(3) "f"(1), the person may request the department to perform an evaluation under paragraph 110.7(3) "g" to determine whether prohibition of the person's involvement with child care continues to be warranted.

*g. Evaluation required.* For all other transgressions, and as requested under subparagraph 110.7(3) "f"(2), the department shall evaluate the transgression and make a decision about the person's involvement with child care.

(1) The person with the transgression shall complete and return the record check evaluation form within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(2) The department may use information from the department's case records in performing the evaluation.

(3) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

*h. Evaluation decision.* The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements or corrective action plan.

(1) Within 30 calendar days of receipt of a completed record check evaluation, the department shall make a decision on the person's involvement with child care.

(2) Within 30 calendar days of receipt of a completed record check evaluation, the department shall mail to the person subject to an evaluation a record check decision that explains the decision reached regarding the evaluation of the transgression and a notice of decision: child care.

(3) The department shall issue a notice of decision: child care prohibiting involvement with child care when the person subject to an evaluation fails to complete the record check evaluation within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan or both. For an employee of a registrant, these conditional requirements shall be developed with the registrant. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the registrant.

*i. Notice to parents of abuse in care.* If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care. The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in revocation of registration.

**110.7(4)** Letter of revocation. A letter received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny or revoke an owner's or operator's certificate of registration.

**110.7(5)** If the department has denied or revoked a registration because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and 441—Chapter 110, the person shall not own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department shall not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

**110.7(6)** Required notifications. If a certificate of registration is revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides care. The provider shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

[ARC 0418C, IAB 10/31/12, effective 1/1/13; ARC 0715C, IAB 5/1/13, effective 7/1/13; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 1809C, IAB 1/7/15, effective 3/1/15]

**441—110.8(237A) Additional requirements for child development home category A.** In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category A shall meet the following standards:

**110.8(1) Limits on number of children in care.**

*a.* No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school may be present for a period of less than two hours at a time.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

**110.8(2) Provider qualifications.**

a. The provider shall be at least 18 years old.

b. The provider shall have three written references which attest to character and ability to provide child care.

**441—110.9(237A) Additional requirements for child development home category B.** In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category B shall meet the following standards:

**110.9(1) Limits on number of children in care.**

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, not more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than four children who attend school may be present.

d. In addition to these ten children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

f. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years old.

**110.9(2) Provider qualifications.**

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma or GED.

c. The provider shall either:

(1) Have two years of experience as a registered or nonregistered child care provider, or

(2) Have a child development associate credential or any two-year or four-year degree in a child-care-related field and one year of experience as a registered or nonregistered child care home provider.

**110.9(3) Facility requirements.**

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

**441—110.10(237A) Additional requirements for child development home category C.** In addition to the requirements in rule 441—110.5(237A), a provider requesting registration in child development home category C shall meet the following standards:

**110.10(1) Limits on number of children in care.**

a. No more than 12 children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these 12 children, not more than 4 children who are 24 months of age or younger shall be present at any one time. Whenever 4 children who are under the age of 18 months are in care, both providers shall be present.

c. In addition to the 12 children not in school, no more than 2 children who attend school may be present for a period of less than two hours at any one time.

d. In addition to these 14 children, no more than 2 children who are receiving care on a part-time basis may be present.

e. No more than 16 children shall be present at any one time when an emergency school closing is in effect. If more than 8 children are present at any one time due to an emergency school closing exception, the provider shall be assisted by a department-approved assistant who is at least 18 years of age.

f. If more than eight children are present, both providers shall be present. Each provider shall meet the provider qualifications for child development home category C.

**110.10(2) Provider qualifications.**

a. One provider who meets the following qualifications must always be present:

(1) The provider shall be at least 21 years old.

(2) The provider shall have a high school diploma or GED.

(3) The provider shall either:

1. Have five years of experience as a registered or nonregistered child care provider, or

2. Have a child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.

b. The coprovider shall meet the requirements of subrule 110.9(2).

**110.10(3) Facility requirements.**

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

**441—110.11(237A) Complaints.** The department shall conduct an on-site visit when a complaint is received.

**110.11(1)** After each complaint visit, the department shall document whether the child development home was in compliance with registration requirements.

**110.11(2)** The written documentation of the department's conclusion as to whether the child development home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

**441—110.12(237A) Registration actions for nonpayment of child support.** The department shall revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

**110.12(1) Service of notice.** The notice required by Iowa Code section 252J.8 shall be served upon the applicant or registrant by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rules of Civil Procedure 56.1. Alternatively, the applicant or registrant may accept service personally or through authorized counsel.

**110.12(2) Effective date.** The effective date of the revocation or denial of the registration as specified in the notice required by Iowa Code section 252J.8 shall be 60 days following service of the notice upon the applicant or licensee.

**110.12(3) Preparation of notice.** The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or registrant.

**110.12(4) Responsibilities of registrants and applicants.** Registrants and registrant applicants shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in the actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

**110.12(5) District court.** A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

*a.* The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

*b.* For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

**110.12(6) Procedure for notification.** The department shall notify the applicant or registrant in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration, and shall similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

**110.12(7) Appeal rights.** Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue, but may request a court hearing pursuant to Iowa Code section 252J.9.

**441—110.13(237A) Transition exception.** The following transition exceptions shall apply to providers renewing a valid previously issued child care home registration on or after December 1, 2002:

**110.13(1)** If the provider is providing child care to four infants at the time of renewal, the provider may continue to provide child care to those four infants. However, when the provider no longer provides child care to one or more of the four infants, or one or more of the four infants reaches the age of 24 months, this exception shall no longer apply. This exception does not affect the overall limit on the number of children in care under the child development home category within which the provider is registered.

**110.13(2)** If the provider is providing child care to school-age children in excess of the number allowable for the provider's registration category at the time of renewal, the provider may continue to provide care to those children and may exceed the total number of children authorized for that category by the excess number of school-age children. This exception is subject to the following conditions:

*a.* The maximum number of children attributable to this exception is five.

*b.* The provider must comply with the other requirements limiting the number of children under that registration category.

c. If more than eight children are present at any one time for more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years of age.

d. When the provider no longer provides child care to one or more of the school-age children who was receiving child care at the time of registration, the excess number of children allowed under this exception shall be reduced accordingly.

**441—110.14(237A) Prohibition from involvement with child care.** If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

These rules are intended to implement Iowa Code section 234.6 and chapter 237A.

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[Filed ARC 1809C (Notice ARC 1705C, IAB 10/29/14), IAB 1/7/15, effective 3/1/15]

- <sup>1</sup> January 1, 2015, effective date of ARC 1636C [110.5(1)“a”] delayed 70 days by the Administrative Rules Review Committee at its meeting held October 14, 2014.



CHAPTER 117  
FOSTER PARENT TRAINING

PREAMBLE

These rules describe required foster parent orientation, preservice training and in-service training. Their purpose is to ensure that the training and orientation are effective in preparing foster parents for their role.

These rules also describe the standards for training and orientation and the procedure to be approved as a training provider.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—117.1(237) Required preservice training.** Foster parent preservice training shall be offered by the department or by a licensed child-placing agency through a training program that has been approved by the department pursuant to rule 441—117.5(237).

**117.1(1) Preservice training requirement.** Each individual foster parent applicant shall complete the entire 30-hour preservice training as approved by the foster family program manager.

*a.* Applicants shall complete the 30-hour preservice training before receiving a license for the first time.

*b.* Applicants shall retake the 30-hour preservice training if they do not complete the curriculum within 24 months after initially commencing it.

*c.* The department may waive the preservice training requirement in whole or in part when the department finds that:

(1) The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

(2) There is good cause for the waiver based upon the circumstances of the child and the applicant.

**117.1(2) Preservice training program approval requirements.**

*a. Content.* The program shall be designed to assist prospective foster parents in developing the understanding and abilities that are essential to promote children's safety, permanence, and well-being. The program shall address the following topics:

(1) Children in foster care, their needs and rights.

(2) Families of children in foster care, their rights and responsibilities.

(3) Caseworkers and their role.

(4) Foster parents, their motivation and role.

(5) Self-assessment of foster parent's strengths.

(6) The team effort of foster parents and caseworkers.

(7) The impact of foster care placement on the child, the child's family and the foster family.

(8) The purpose and importance of the child's contact with the child's family.

(9) Training in communication and behavior management.

(10) Permanency planning.

(11) The reasons for placement termination and feelings involved.

*b. Length.* The entire preservice training program shall total at least 30 hours of contact between leaders and participants. The department's recruitment and retention contractor shall devise a procedure for applicants to make up any portions of the preservice training that are missed.

*c. Instructors.* The program shall be team taught by at least one foster or adoptive parent and one casework staff person. All instructors shall be certified leaders or as approved by the adult, children and family services division administrator or designee.

*d. Group method.* The program shall be provided in groups that consist of six or more persons. The training shall be offered to a foster family individually only when the foster family is unable to attend group training for reasons such as serious medical conditions, as approved by the social work administrator or designee.

*e. Training certificate.* A certificate of completion shall be provided to each foster parent who completes the training.

*f. Training evaluation.* A means for participants in the training to evaluate the instructors and the content shall be provided.

*g. Training records.* A record of the applicants who begin and complete the training and of the training program evaluations shall be submitted to the recruitment and retention contractor at the end of each 30-hour preservice training session.

**117.1(3) Universal precautions.** Before licensure, each individual foster parent shall complete one hour of training related to the use and practice of universal precautions. Training shall be completed through the approved individual self-study course, “Universal Precautions in Foster and Adoptive Resource Family Homes.”

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1808C, IAB 1/7/15, effective 3/1/15]

**441—117.2(237) Required orientation.** All foster parent applicants shall attend orientation before attending the 30-hour preservice training and before a foster child is placed in their home. Orientation shall not count toward the required 30 hours of preservice training.

**117.2(1) Method of provision.** The recruitment and retention contractor may provide orientation:

- a.* In an individual meeting with one set of foster parent applicants; or
- b.* In a group setting.

**117.2(2) Provider.** Orientation shall be provided by the recruitment and retention contractor completing the family’s licensing study.

**117.2(3) Content.** Orientation shall be designed to provide the foster parent applicant with information on the policies and procedures of the foster care and adoption programs and shall include the following:

- a.* Process and procedures for placement and termination of placement.
- b.* Medical assistance program information.
- c.* Foster family reimbursement information and adoption subsidy information if applicable.
- d.* Child abuse law and child abuse investigation procedures.
- e.* Confidentiality.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1808C, IAB 1/7/15, effective 3/1/15]

**441—117.3(237) Application materials for in-service training.** Applications for approval of an in-service training program shall be submitted on Form 470-2541, Foster Parent Training Application, and must be approved before the delivery of the training. Applications submitted after a training is completed shall not be approved.

**117.3(1)** Except for cardiopulmonary resuscitation and first-aid training, foster parent in-service training shall meet the requirements in rule 441—117.7(237).

**117.3(2)** Applications shall be submitted with the following materials:

*a.* A detailed training program description relative to a foster parent, including objectives, program agenda, content, participant materials, and time frames.

*b.* Names of program instructors and their qualifications to provide the training.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—117.4(237) Application process for in-service training.**

**117.4(1) Group training.** Applications to provide group foster parent training shall be submitted to the department office for the service area in which the training will be conducted.

**117.4(2) Individual training.** Applications for approval for individual training, college credit, written materials, DVDs or videotapes shall be submitted to the department office for the service area in which the foster family resides.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—117.5(237) Application decisions.** The department shall notify the applicant of its decision regarding the application for approval of in-service training within 30 days of receipt of the training

materials described in rule 441—117.3(237). This notification shall include the reason for not giving approval if approval is denied.

**117.5(1) Approval.** Foster parent training programs which meet the criteria in rule 441—117.1(237) or in rule 441—117.7(237) and which are submitted pursuant to rules 441—117.3(237) and 441—117.4(237) shall be approved by the department. In-service training completed before the program has received department approval shall not count toward the required six credit hours of in-service training. In-service training approvals are valid for one year.

**117.5(2)** Rescinded IAB 8/9/89, effective 10/1/89.

**117.5(3) Denial.** Preservice training programs which do not meet the requirements in rules 441—117.1(237), 117.3(237), and 117.4(237) and in-service training programs which do not meet the criteria in rules 441—117.3(237), 117.4(237) and 117.7(237) shall be denied approval. The applicant may submit a revised program for approval at a later date.

**117.5(4) Revocation.** Approval shall be revoked when any of the following exist and corrective action is not taken to correct the deficiencies within 45 days.

*a.* The training provider fails to provide the training as described in the approved application materials.

*b.* Over 25 percent of the participant evaluations of the training program rate the training program as not helpful.

If approval is revoked, the training provider may submit a revised program at a later date.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—117.6(237) Application conference available.** If an applicant or provider of training objects in writing within seven days after the notification of the department's decision to deny approval, the area social work administrator shall review the decision to determine if the original decision shall stand. The decision of the area social work administrator is final and is not subject to appeal.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—117.7(237) Required in-service training.** Training is required to assist foster parents in confidently and effectively addressing the needs of children placed in foster care. The Foster Parent Training Plan, Form 470-3341, shall be used to address in-service training needs. The training plan shall be developed with the department or retention and recruitment contractor and the foster parent at annual licensing renewal.

**117.7(1) Providers of in-service training.** Foster parent in-service training may be provided by the department, a licensed child-placing or child-caring agency, or an agency, institution, or association with expertise in the training content. Agencies, institutions, or associations wishing to have a foster parent in-service training program or workshop approved shall submit application materials pursuant to rules 441—117.3(237) and 441—117.4(237).

**117.7(2) In-service training program approval requirements.**

*a. Content.* The program shall relate to the foster parent's role in providing foster care and the skills needed by a foster parent. Training shall be specific to developing each foster parent's skills for addressing the needs of foster children.

*b. Method.* The training shall be provided through one or more of the following methods:

(1) Face-to-face training to a group.

(2) Face-to-face training to an individual foster family.

(3) Written materials.

(4) DVDs or videotapes.

(5) Internet training classes offered through the Iowa Foster and Adoptive Parents Association (IFAPA).

(6) Internet training classes offered through [www.fosterparents.com](http://www.fosterparents.com), except for cardiopulmonary resuscitation and first-aid trainings, which are not approved.

*c. Credit hours.* Credit hours for approved training shall be as follows:

(1) Group training shall receive one credit hour for each face-to-face contact hour.

(2) Written materials shall receive one credit hour for each 100 pages.

- (3) DVDs or videotapes shall receive one credit hour for each two program hours.
- (4) College courses shall receive one credit hour for each college credit hour.
- (5) Internet training classes shall receive one credit hour for each program hour. A maximum of three hours of training credit per year may be earned through the Web site [www.fosterparents.com](http://www.fosterparents.com).

*d. Approved training.* The following training programs shall be considered as meeting the in-service training requirements:

- (1) Workshops offered at the Iowa Association of Foster and Adoptive Parents' annual state conference.
- (2) Workshops offered at the National Foster Parent Association's annual conference.
- (3) Rescinded IAB 8/9/89, effective 10/1/89.

**117.7(3) Foster parent training requirements.** Each individual foster parent shall complete six credit hours of department-approved in-service training annually. Failure to meet the requirement for in-service training hours will result in denial of the license renewal.

*a. Training cycle.* "Annually" means within the annual training cycle as described in this paragraph.

(1) Initial license. For a newly licensed foster parent, the initial training cycle shall be the 10-month period ending 2 months before the license expires. EXAMPLE: The initial training cycle for a new license effective June 1 is June 1 through March 31.

(2) Renewal license. For a one-year license renewal, the annual training cycle shall be the 12-month period beginning 2 months before the expiration of the previous license and ending 2 months before the expiration of the subsequent license. EXAMPLE: The training cycle for a license effective June 1 would be April 1 through March 31 of the subsequent year. For a two-year license renewal, the training cycle for the first year shall be the 12-month period beginning 2 months before the expiration of the previous license year and ending 10 months after the effective date of the two-year license. The annual training cycle for the second year of a two-year license shall be the 12-month period beginning 11 months after the effective date of the first year of the license and ending 2 months before the expiration of the license.

*b. Content.* The choice of in-service training shall be based upon an assessment of the foster parent's training needs made by the foster parent and the recruitment and retention contractor in collaboration with the department licensing worker.

- (1) Each foster parent must complete the specific training required in rule 441—117.8(237).
- (2) At least three credit hours of the annual training shall be group training.
- (3) Except for the classes for mandatory reporters, cardiopulmonary resuscitation, and first aid, training credit will not be allowed for any in-service training class that is repeated.

*c. Documentation.* Each individual foster parent shall submit Form 470-2540, Foster Parent Training Report, to the recruitment and retention contractor within 30 days after completion of each in-service training.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 0356C, IAB 10/3/12, effective 12/1/12]

#### **441—117.8(237) Specific in-service training required.**

**117.8(1) Medication management.** Within the initial training cycle, each individual foster parent shall complete one hour of training related to the use and practice of medication management.

*a.* Training shall be completed through the approved individual self-study course, "Medication Management."

*b.* One hour of in-service training credit shall be allowed for completion of this self-study course. This course cannot be repeated for in-service training credit.

*c.* Foster parents who are already licensed on October 1, 2009, shall complete this training by October 1, 2010.

**117.8(2) Cardiopulmonary resuscitation (CPR).** All foster parents shall be certified in CPR every three years and shall maintain a certificate indicating the date of training and expiration.

*a.* The training shall be provided by:

- (1) A nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid), or

(2) An equivalent certified trainer and curriculum approved by the department.

b. Newly licensed foster parents shall complete the training before the end of their initial training cycle. Foster parents who are already licensed on October 1, 2009, shall complete this training by October 1, 2010.

**117.8(3) First aid.** All foster parents shall be certified in first aid every three years and shall maintain a certificate indicating the date of training and expiration. Newly licensed foster parents shall complete the training before the end of their initial training cycle. Foster parents who are already licensed on October 1, 2009, shall complete this training by October 1, 2010.

**117.8(4) Child abuse reporting.** Each foster parent shall complete approved training relating to the identification of child abuse and requirements and procedures for the reporting of child abuse pursuant to Iowa Code section 232.68.

a. *Training cycle.* Newly licensed foster parents shall complete mandatory reporter training before the end of their initial training cycle. The training shall be repeated every five years thereafter.

b. *Training provider.* The foster parent shall be responsible for obtaining the required two-hour mandatory reporter training in child abuse identification and reporting as approved by the Iowa department of public health. A list of approved training opportunities is available at: [http://www.idph.state.ia.us/bh/abuse ed review.asp](http://www.idph.state.ia.us/bh/abuse_ed_review.asp).

c. *Documentation.* The foster parent shall secure documentation of the training content, amount, and provider and shall forward the documentation to the recruitment and retention contractor, who will provide the documentation to the department for inclusion in the foster parent's licensing file.

**117.8(5) Caring for children with HIV.** Before placement of an HIV-infected child occurs, the foster parents shall complete the course “Caring for Children With HIV” or an approved alternative course that contains information on the unique aspects of pediatric HIV disease, transmission and infection control, the spectrum of HIV disease, confidentiality, death and bereavement, and self-care for the caregiver.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—117.9(237) Foster parent training expenses.** No expense stipend is provided for orientation or preservice training.

**117.9(1) Training stipend.** Each family that is issued an initial or renewal foster family home license shall receive a \$100 stipend to be used for the family’s annual in-service training. The department’s recruitment and retention contractor shall issue one stipend per license on or after the date that the license is issued. When a family with a two-year foster family home license has completed the first training cycle of six hours of in-service training, the contractor shall issue the next training stipend no earlier than the start of the second year of licensure contingent upon the foster family’s completion of the in-service training hours in the first cycle. Foster families who elect not to receive the \$100 stipend shall notify the department.

**117.9(2) Trainer fees.** Foster parents and social workers who serve as trainers for approved preservice training programs shall each be paid a contract fee per class hour appropriate to community standards based upon the education and experience of each trainer. These rates shall be negotiated between the recruitment and retention contractor and the trainer.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 0356C, IAB 10/3/12, effective 12/1/12]

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TITLE XVI  
ALTERNATIVE LIVINGCHAPTER 200  
ADOPTION SERVICES

[Prior to 7/1/83, Social Services[770] Ch 139]  
[Previously appeared as Ch 139—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

## PREAMBLE

These rules define and structure the adoption services to be provided to birth families, children legally available for adoption, prospective adoptive families and adoptive families. These rules also establish policy regarding requests for access to sealed records.

**441—200.1(600) Definitions.**

*“Adoption”* means a legal and social process through which a child becomes a member of a family into which the child was not born. Adoption provides the child the same rights, privileges and duties as a birth child.

*“Adoption service”* means a service directed towards children who are legally available for adoption, the birth family, prospective adoptive family and adoptive family.

*“Adoption work experience”* means supervised employment in adoption services, which includes direct provision of adoption services, development of adoption policies, provision of training related to adoption services, oversight and review of adoption documents and activities, and direct supervision of adoption workers. Only the percent of time related to provision of adoption services shall be considered as adoption work experience when job duties involve activities other than adoption services.

*“Adoptive family”* means an approved person or persons who have a child placed in their home and are being supervised prior to finalizing the adoption; or who have a child in their home who is legally adopted and entitled to the same benefits as a child born into the family.

*“Adoptive home study”* includes an assessment of the family’s parental attributes and a written report stating approval or nonapproval of the family for adoptive placement of a child or children.

*“Certified adoption investigator”* means a person as defined at rule 441—107.2(600).

*“Child study or social history”* includes a written description of the child including strengths and needs; medical, mental, social, educational, placement and court history; a description of the child’s relationships with the birth family, foster family, and significant others; a summary of the child’s understanding and feeling about adoption and recommendations as to the type of family that can best meet the child’s needs.

*“Court-ordered studies”* means home studies ordered by a judge for the purpose of determining custody of a child or placement of a child for the purpose of adoption.

*“Department”* means the department of human services.

*“Family safety, risk, and permanency service”* means a service provided under 441—Chapter 172 that uses strategies and interventions designed to achieve safety and permanency for a child with an open department child welfare case, regardless of the setting in which the child resides.

*“Foster family adoption”* means the adoption of a child by a licensed foster family who has cared for the child.

*“Guardianship record”* means a case record regarding a child, established and retained by the department, when the department is named guardian of the child by court order. The purpose of the guardianship record is to collect and maintain information about the child and the birth family, legal documents, and other information that will assist in fulfilling the responsibility of guardian.

*“Life book”* means a compilation of information about the child, including birth information, photographs of the child; placement history, including dates of placement, names of caretakers, reasons for leaving the placement; relationships; school reports; social, medical, mental health developmental

history; awards received, important events, letters from significant persons, and other information that the child wishes to include. The life book will assist the child in dealing with separation and loss issues and provide background and genealogy data.

*“Mental health professional”* means a psychiatrist, psychologist, social worker, psychiatric nurse or mental health counselor who holds a current license as required by law.

*“Placement services”* includes the activities and travel necessary to place the child in the adoptive family.

*“Postadoption services”* includes those services that an adoptive family may access after the adoption is finalized to assist the family in coping with and resolving problems within the family.

*“Postplacement services”* includes the supervision, support and intervention necessary prior to finalization to assist in maintaining the adoptive placement.

*“Preadoptive family”* means an approved adoptive family with a child placed in the home for adoption whose adoption has not been finalized.

*“Preparation of child”* includes activities necessary to ready the child for placement into an adoptive family.

*“Preparation of family”* includes the activities necessary to assist the family in adding an adoptive child as a new member of their family.

*“Preplacement visits”* means contacts, activities, and visits between the child and adoptive family prior to the adoptive placement.

*“Procedendo”* means an order issued by the supreme court returning jurisdiction to the district court after a final appellate decision regarding an appeal.

*“Recruitment and retention contractor”* means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

*“Relative within the fourth degree of consanguinity”* means an adult who is related to a child as follows:

1. The child’s parent, brother, or sister (first degree);
2. The child’s grandparent, aunt, uncle, niece, nephew, or first cousin (second degree);
3. The child’s great grandparent, great aunt, great uncle, great niece, great nephew, first cousin once removed, or second cousin (third degree); or
4. The child’s great-great grandparent, great-grand aunt, great-grand uncle, great-grand niece, great-grand nephew, first cousin twice removed, second cousin once removed, or third cousin (fourth degree).

*“Release of custody services”* includes providing information regarding options to assist the parents in making permanent plans for their child and counseling regarding personal and emotional issues as described in 441—subrule 108.9(2).

*“Selection of family”* means reviewing approved home studies to match a family’s strengths with a specific child’s needs.

*“Special needs child”* means a child who meets one or more of the criteria set forth at 441—subrule 201.3(1).

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1754C, IAB 12/10/14, effective 2/1/15]

**441—200.2(600) Release of custody services.** This rule applies to all terminations filed under Iowa Code chapter 600A. The parents shall be offered a minimum of three hours of counseling by a person authorized to provide counseling in accordance with 441—paragraph 108.9(2)“f.”

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1754C, IAB 12/10/14, effective 2/1/15]

**441—200.3(600) Application.** Persons wishing to apply to adopt a child through the department shall complete an Application for Adoption form. An application for adoption shall only be accepted for children who are under the guardianship of the department.

**200.3(1) Limitations.** The department and its recruitment and retention contractor shall accept only applications for adoption of a special needs child. Applications for adoption of a child without special needs shall be referred to private child-placing agencies. Exceptions to this rule may be made for:

- a. Relatives of a child under the guardianship of the department; or
- b. Foster parents with whom the child has a significant relationship.

**200.3(2) Procedures.** An application for adoption of a special needs child shall be accepted by any department office or by the department's recruitment and retention contractor. Before a home study is completed, applicants shall:

- a. Complete the Application for Adoption form, and
- b. Ensure that the Physician's Report for Foster and Adoptive Parents form is completed by the applicant's family physician.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1754C, IAB 12/10/14, effective 2/1/15]

**441—200.4(600) Adoption services.** Adoption services shall include: adoptive home study, preparation of child, selection of family, preparation of family, preplacement visits, placement services, and postplacement services.

**200.4(1) Adoptive home study.** For applicants who apply to the department to adopt, the recruitment and retention contractor shall prepare an adoptive home study through the following activities:

a. *Family assessment.* The family assessment shall include a minimum of two face-to-face interviews with the applicants and at least one face-to-face interview with each member of the household. At least one of the interviews shall take place at the applicant's home. The assessment of the prospective adoptive family shall include an evaluation of the family's ability to parent a special needs child or children including the following:

- (1) Motivation for adoption and whether the family has biological, adopted or foster children.
- (2) Family's and extended family's attitude toward accepting an adopted child and plans for discussing adoption with the child.
- (3) The attitude toward adoption of other people involved with the family in a significant way.
- (4) Emotional maturity; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents.
- (5) Ability to cope with problems, stress, frustrations, crises, separation, and loss.
- (6) Medical, mental and emotional conditions that may affect the applicant's ability to parent a child, treatment history, and current status of treatment.
- (7) Willingness to accept a child who has medical problems (such as a child who is at risk for HIV or is HIV positive), intellectual disabilities, or emotional or behavioral problems. Ability to provide for the child's physical, medical and emotional needs and respect the child's ethnic and religious identity.
- (8) Description of biological children and previously adopted children, if any, including their attitudes toward adoption, relationship with others, and school performance.
- (9) Capacity to give and receive affection.
- (10) Statements from three references provided by the family and additional references the worker for the recruitment and retention contractor may wish to contact.
- (11) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.
- (12) Financial information, including the family's ability to provide for a child.
- (13) Disciplinary practices that will be used.
- (14) History of abuse involving family members, including how the abuse was addressed and how that history impacts the applicant's ability to be an adoptive parent.
- (15) Assessment of, commitment to, and capacity to maintain other significant relationships.
- (16) Substance use or abuse by members of the household, treatment history and current status of treatment.
- (17) Recommendations for the number, age, sex, characteristics, and special needs of a child or children the family can best parent.
- (18) The family's ability to anticipate and understand the special needs of an adopted child as the child gets older and how the family will manage those needs.

b. *Record checks.* Record checks are required for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether any of those persons have

founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The department's contractor for the recruitment and retention of resource families shall assist applicants applying through the department in completing required record checks, including fingerprinting.

(1) The records of the applicants shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse Information form;
2. By the Iowa division of criminal investigation, using the DHS Criminal History Record Check Form B;
3. On the Iowa sex offender registry;
4. On the child abuse registry of any state where the applicant has lived during the five years prior to the issuance of the investigative report; and
5. For a national criminal history through fingerprinting or another biometric identification-based process accepted by the federal government.

(2) The records of persons aged 14 or older living in the home of the applicant shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse Information form;
2. By the Iowa division of criminal investigation, using the DHS Criminal History Record Check Form B; and
3. On the Iowa sex offender registry.

(3) Out-of-state child abuse checks and national criminal history checks may be completed on any adult living in the home of the applicant if the department has reason to do so.

(4) The department shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2) "b."

(5) The department shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has committed a crime in a state other than Iowa that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2) "b."

*c. Evaluation of record.*

(1) If the applicant or anyone living in the home has a record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the applicant shall not be approved to adopt unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

(2) The evaluation shall be conducted according to procedures in 441—subrules 113.13(2) and 113.13(3) for applications for adoption through the department or procedures in 441—paragraph 108.9(4) "e" for applications for adoption through a child-placing agency.

*d. Written report.* The worker for the recruitment and retention contractor shall prepare a written report of the family assessment, known as the adoptive home study, using the PS-MAPP family profile format. The worker for the recruitment and retention contractor shall use the home study to recommend to the department to approve or deny a prospective family as an appropriate placement for a child or children. The worker and supervisor for the recruitment and retention contractor shall date and sign the adoptive home study.

(1) The department shall notify the family of the decision using the Adoption Notice of Decision form.

(2) If the department does not approve the home study, the reasons shall be stated on the notice.

(3) The department shall provide the family a copy of the adoptive home study with the notification of approval or denial.

*e. Preplacement assessment and home study update.* A preplacement assessment and home study update is required if the adoptive home study was written more than two years previously, in accordance with Iowa Code section 600.8. The preplacement assessment and home study update shall be conducted by completion of the following:

(1) The child abuse and criminal record checks shall be repeated, except for fingerprinting. If there are any founded abuses or convictions of crimes that were not evaluated in the previous home study, they shall be evaluated using the process set forth in paragraph 200.4(1) "c."

(2) One face-to-face visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) An updated written report of the reassessment and adoptive home study shall be written, dated, signed by the worker and the supervisor for the recruitment and retention contractor, and a copy provided to the adoptive family.

(5) Families who are dually licensed to provide foster family care shall have their adoption approval date align with their foster home licensing date.

*f. Procedure for foster parent adoptions.* When a licensed foster parent applies for approval as an adoptive home, home study activities that have been completed within the previous year as part of a licensing study pursuant to 441—Chapter 113 need not be repeated.

*g. Annual visits to the adoptive family home.* The recruitment and retention contractor shall complete a minimum of one visit each year in the homes of families approved to adopt.

(1) The visit shall not be waived.

(2) When a person aged 14 or older moves into the home, the agency shall perform checks on the Iowa central abuse registry, by the division of criminal investigation, and on the sex offender registry. The record check evaluation process shall be completed if the person has a criminal conviction or founded abuse report or is on the sex offender registry.

(3) Findings and observations of the visit shall be documented and provided to the department when the update is submitted.

(4) The department shall be notified within 30 days of any deficiencies noted or other concerns discovered that require corrective action.

**200.4(2) Preparation of child.** The department worker shall conduct specific activities designed to enable a child to make the transition to an adoptive placement or refer the child to the family safety, risk, and permanency services contractor or other professionals. The activities shall include, but not be limited to:

*a.* Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

*b.* Assisting in the preparation or update of a life book.

*c.* Provision of age-appropriate information regarding community resources available, such as children's support groups, to assist the child in the transition and integration into the adoptive family.

*d.* Any appropriate evaluations or testing.

*e.* HIV testing of a child by the University of Iowa Hospitals and Clinics (UIHC) or a local physician when any of the following conditions exist:

(1) The child was, or may have been, sexually abused by a person who participated in high-risk behavior such as sharing of needles with an infected person or sex participation with an infected person.

(2) The child's birth mother participated in high-risk behavior, or is HIV positive.

(3) The child participated in, or has participated in, high-risk behavior.

(4) The child is symptomatic or at high risk of infections.

(5) There is a lack of medical information regarding the birth parents or the child.

**200.4(3) Selection of family.** The family that can best meet the needs of the adoptive child shall be selected as follows:

*a.* Before preplacement visits occur, a conference shall be held to select an approved family. A minimum of two department social workers and a department supervisor shall be included in the conference. The child's special needs, characteristics, and anticipated behaviors shall be reviewed in the conference to determine a family that can best meet the needs of the child. Approved families shall also be reviewed in an effort to match the specific family's parenting strengths with a particular child's needs.

*b.* The following selection criteria shall be observed:

(1) Preference shall be given to placing children from the same birth family together. If placement together is not possible, or is not in the best interest of the children, the reasons shall be identified and documented in each child's case record. Efforts shall be made to ensure continuous contact between siblings when the siblings are not placed together.

(2) Race, color, or national origin may not be routinely considered in placement selections except when an Indian child is being placed pursuant to Iowa Code section 232.7 or Iowa Code chapter 232B. Placement decisions shall be made consistent with the best interests and special needs of the child.

(3) A relative who is within the fourth degree of consanguinity shall be given consideration for selection as the adoptive family for a child who is legally available for adoption if the child has a significant relationship with the relative or the child is aged 14 or older and elects adoption by the relative.

(4) Foster parents shall be given consideration for selection as the adoptive family for a child in the foster parents' care who is legally available for adoption if the child has been in the foster parents' care for six months or longer or the child has a significant relationship with the family.

**200.4(4) Preparation of family.** The recruitment and retention contractor and the department shall conduct activities designed to enhance the family's readiness to accept the child or children into the family and strengthen the family's commitment to adopt. A referral may be made for family safety, risk, and permanency services if needed. The activities shall include, but not be limited to:

a. Completion of at least 30 hours of preservice training and the self-study course, "Universal Precautions in Foster and Adoptive Family Homes," before placement of a child. These training requirements apply to families who are adopting special needs children who are under the guardianship of the department.

(1) Foster parents licensed before December 31, 2002, who have been caring for a foster child in their home for at least six months and who have been selected to adopt that child may have their participation in adoption training waived by the service area manager or designee.

(2) Relatives who have cared for a related child for at least six months and who have been selected to adopt that related child may have their participation in the preservice training waived by the service area manager or designee.

(3) The department may waive the 30-hour preservice training requirement in whole or in part when the department finds that:

1. The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

2. There is good cause for the waiver based upon the circumstances of the child and the applicant.

(4) If the adoptive parents are accepting placement of a child who is at high risk of becoming or is HIV positive, they shall also complete the "Caring for Children With HIV" course.

(5) Applicants must retake the 30-hour preservice training if the adoption approval process is not completed within 24 months after the preservice training is initially completed.

b. Discussion with family members regarding problems resulting from a child's separation, loss, grief, and anger due to the loss of the birth parents.

c. Provision of background information on the child and birth family, including a child study that includes experiences such as foster and adoption placements and other pertinent information and the child's life book.

d. Provision of information regarding the child's special needs and behavior patterns.

e. Provision of a description of the child's medical needs, including whether or not the child is at risk of or is HIV positive.

f. Discussion of the impact that adding a new member or members to the family may have on all current family members.

g. Explanation of the subsidized adoption program.

h. Provision of information regarding the community resources that are available to assist the family, such as parent support groups.

**200.4(5) Preplacement visits.** The department worker shall plan, conduct and assess the transitional visits between the adoptive family and the child or children before the adoptive placement of the child in the home.

**200.4(6) Placement services.** Placement services include the activities necessary to plan and carry out the placement of a child or children into the adoptive family.

Before placement of a child, the Agreement of Placement for Adoption, Form 470-0761, shall be signed by all parties.

**200.4(7) Postplacement services.** An adoptive family is eligible for postplacement services from the time a child is placed with the family until finalization of the adoption occurs. The department worker shall supervise the placement, provide ongoing support to the child and family, perform crisis intervention, and complete required reports. Assistance with behavioral interventions to strengthen the placement and prevent disruption may be provided through family safety, risk, and permanency services.

- a.* Postplacement supervision shall focus on the following areas:
- (1) Integration and interaction of the child or children with the family.
  - (2) Changes in the family functioning which may be due to the child's placement.
  - (3) Social and emotional adjustment of the child or children.
  - (4) Child's growth and development since placement with the adoptive family.
  - (5) Changes and adjustments that have been made in the family since the child's placement.
  - (6) Family's method of dealing with testing behaviors and discipline.
  - (7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.
  - (8) School adjustment of a child who is attending a school.
  - (9) The behavioral needs of the child.
  - (10) The psychological and mental health needs of the child.
  - (11) Services and supports that will assist the child and family in the future.

*b.* At a minimum, the department worker shall make monthly home visits until the adoption is final. If the family is experiencing problems, the department worker shall make as many visits as are necessary to assess and support the placement.

*c.* The department worker shall prepare a written report based on the postplacement visits with recommendations regarding the finalization of the adoption and submit the report to the court before the hearing to consider granting a decree of adoption.

**200.4(8) Postadoption services.** The department's recruitment and retention contractor shall provide postadoption services to families that are eligible for the department's adoption subsidy program in accordance with the contract. The goal of these services is to prevent adoption dissolution. The family may obtain additional support through community resources or support groups.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1754C, IAB 12/10/14, effective 2/1/15; ARC 1808C, IAB 1/7/15, effective 3/1/15]

**441—200.5(600) Termination of parental rights.** The department shall not place a child in an approved adoptive home until parental rights of the child's birth parents have been terminated and guardianship assigned to the department. If one or both birth parents are deceased, the worker shall provide the court with verification of the birth parents' death and the death shall be stated in the guardianship order. When the termination of parental rights is appealed by a birth parent, an adoptive placement may be made if the adoptive parents sign an adoptive placement agreement that includes an acknowledgment of the conditions of the placement should termination be overturned. However, the adoption may not be finalized until the appeal is withdrawn or a final decision regarding the appeal is reached and a procedendo issued.

**441—200.6(600) Service provision.** Rescinded IAB 7/29/09, effective 10/1/09.

**441—200.7(600) Department fees.** Rescinded IAB 7/29/09, effective 10/1/09.

**441—200.8(600) Interstate placements.** Interstate placement of a child into Iowa, or out of Iowa, shall follow interstate placement of child procedures in accordance with Iowa Code sections 232.158 through 232.166.

[ARC 1754C, IAB 12/10/14, effective 2/1/15]

**441—200.9(600) International adoptions.** Rescinded IAB 7/29/09, effective 10/1/09.

**441—200.10(600) Requests for home studies.**

**200.10(1) Court-ordered.** Court-ordered home studies for adoption of a child or children under the authority of the department shall be completed by the department's recruitment and retention contractor.

**200.10(2) Interstate compact.** Requests for an adoptive home study through the interstate compact process shall be completed by the department's recruitment and retention contractor.

[ARC 8010B, IAB 7/29/09, effective 10/1/09]

**441—200.11(600) Reasons for denial.** An individual or family shall be denied approval of an adoptive home study for one or more of the following reasons:

**200.11(1) Founded child abuse report.** A founded child abuse report shall mean denial of approval unless an evaluation determines that it does not merit denial.

**200.11(2) Criminal conviction.** A criminal conviction shall mean denial of approval unless an evaluation determines that it does not merit denial.

**200.11(3) Documented concerns.** Concerns may be documented in one or more of the following areas:

- a. Motivation to adopt.
- b. Child-rearing ability and practices.
- c. Emotional stability.
- d. Physical or mental health.
- e. Interpersonal relationships.
- f. Finances.
- g. Marital relationship.
- h. Other areas that may impact the applicant's ability to meet the needs of a child both at present and in the future.

**200.11(4) Substance abuse.** Verified substance use or abuse that prevents the family from adequately caring for the child shall mean denial of approval.

**200.11(5) Lack of cooperation.** If the individual or family fails to cooperate in providing the information needed to complete the preplacement assessment or home study, the application shall be denied.

[ARC 1754C, IAB 12/10/14, effective 2/1/15]

**441—200.12(600) Removal of child from preadoptive family.** When the department determines that it is in the best interest of a child to be removed from a preadoptive family, a Letter of Removal, Form 470-3018, shall be mailed to the family prior to the removal. Removal of a child from a preadoptive family is not an appealable issue, as a child continues to be under the guardianship of the department until an adoption is finalized.

**441—200.13(600) Consents.** A request for consent to the adoption shall be submitted to the guardian for a child who is under the guardianship of the department and for whom finalizing an adoption is recommended. If the adoption is in the best interest of the child, the director or designee shall sign a Consent to Adoption, Form 470-0775, prior to a court hearing to finalize the adoption.

A consent to adopt may be rescinded by the department, by signing Rescinding the Consent to Adoption, Form 470-2990, for any of the following reasons:

1. At the request of the adoptive family.
2. A founded child abuse report, or accusation of child abuse, pending determination of the report.
3. Conviction of a crime, or accusation of a crime, pending a court decision regarding the crime.
4. At the request of a child who is aged 14 or over and has reversed the decision regarding the adoption.
5. Other verified indications that the adoption is not in the best interest of the child.

**441—200.14(600) Requests for access to information for research or treatment.**

**200.14(1) Requests.** Any person seeking access to the department's sealed adoption records for the purpose or purposes set forth in Iowa Code paragraph 600.16(1) "c" or Iowa Code subsection 600.24(2)

shall submit a request in writing to the director. Each request shall contain sufficient facts to establish that the information sought is necessary for conducting a legitimate medical research project, or for treating a patient in a medical facility.

**200.14(2) Process.** Upon receipt of a request for information sought in conducting a research project, the director or a designee shall review the request for information and make a decision to approve, or deny, the request based on the research to be conducted, the benefits of the research, the methodology, and the confidentiality measures to be followed. Upon a request for information for treating a patient in a medical facility, a decision regarding approval or denial shall be made by the director or designee based on the written information provided by a physician or the medical facility, making the request. Requesters shall be notified in writing of approval or denial and if denied, reasons for denial given.

**441—200.15(600) Requests for information for purposes other than research or treatment.** Requests for information from department adoption records for purposes other than research or treatment shall be made to the Department of Human Services, Division of Adult, Children and Family Services, Adoption Program, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

**200.15(1)** The department shall not release identifying information from sealed adoption records. Adult adoptees, adoptive parents, birth parents, siblings or descendants of an adopted person, or legal representatives of any of the above shall be provided:

- a. An adoption packet containing a sample affidavit for filing with the court,
- b. Directions for filing the affidavit,
- c. A list of county clerks of court,
- d. The address of the bureau of vital statistics, and
- e. Instructions on how to obtain the name of the Iowa county where the adoption was finalized, if necessary.

**200.15(2)** An adopted person who was a resident of the Annie Wittenmeyer Home (Iowa Soldier's and Sailor's Home) may receive nonidentifying information from Annie Wittenmeyer records if the information is available.

[ARC 8010B, IAB 7/29/09, effective 10/1/09; ARC 1754C, IAB 12/10/14, effective 2/1/15]

**441—200.16(600) Appeals.** Prospective adoptive families may appeal denial of approval of their home study based on rule 441—200.11(600), pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 600.

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[Prior to 5/18/88, Dental Examiners, Board of[320]]

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CHAPTER 29  
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[Prior to 5/18/88, Dental Examiners, Board of[320]]

**650—29.1(153) Definitions.** For the purpose of these rules, relative to the administration of deep sedation/general anesthesia, moderate sedation, minimal sedation, and nitrous oxide inhalation analgesia by licensed dentists, the following definitions shall apply:

“*Antianxiety premedication*” means minimal sedation. A dentist providing minimal sedation must meet the requirements of rule 650—29.7(153).

“*ASA*” refers to the American Society of Anesthesiologists Patient Physical Status Classification System. Category 1 means normal healthy patients, and category 2 means patients with mild systemic disease. Category 3 means patients with moderate systemic disease, and category 4 means patients with severe systemic disease that is a constant threat to life.

“*Board*” means the Iowa dental board established in Iowa Code section 147.14(1)“*d.*”

“*Capnography*” means the monitoring of the concentration of exhaled carbon dioxide in order to assess physiologic status or determine the adequacy of ventilation during anesthesia.

“*Committee*” or “*ACC*” means the anesthesia credentials committee of the board.

“*Conscious sedation*” means moderate sedation.

“*Deep sedation/general anesthesia*” is a controlled state of unconsciousness, produced by a pharmacologic agent, accompanied by a partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command.

“*Facility*” means a dental office, clinic, dental school, or other location where sedation is used.

“*Maximum recommended dose (MRD)*” means the maximum FDA-recommended dose of a drug as printed in FDA-approved labeling for unmonitored home use.

“*Minimal sedation*” means a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient’s ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected. The term “minimal sedation” also means “antianxiety premedication” or “anxiolysis.” A dentist providing minimal sedation shall meet the requirements of rule 650—29.7(153).

“*Moderate sedation*” means a drug-induced depression of consciousness, either by enteral or parenteral means, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Prior to January 1, 2010, moderate sedation was referred to as conscious sedation.

“*Monitoring nitrous oxide inhalation analgesia*” means continually observing the patient receiving nitrous oxide and recognizing and notifying the dentist of any adverse reactions or complications.

“*Nitrous oxide inhalation analgesia*” refers to the administration by inhalation of a combination of nitrous oxide and oxygen producing an altered level of consciousness that retains the patient’s ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command.

“*Pediatric*” means patients aged 12 or under.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.2(153) Prohibitions.**

**29.2(1) Deep sedation/general anesthesia.** Dentists licensed in this state shall not administer deep sedation/general anesthesia in the practice of dentistry until they have obtained a permit. Dentists shall only administer deep sedation/general anesthesia in a facility that has successfully passed inspection as required by the provisions of this chapter.

**29.2(2) Moderate sedation.** Dentists licensed in this state shall not administer moderate sedation in the practice of dentistry until they have obtained a permit. Dentists shall only administer moderate sedation in a facility that has successfully passed inspection as required by the provisions of this chapter.

**29.2(3) Nitrous oxide inhalation analgesia.** Dentists licensed in this state shall not administer nitrous oxide inhalation analgesia in the practice of dentistry until they have complied with the provisions of rule 650—29.6(153).

**29.2(4) Antianxiety premedication.** Dentists licensed in this state shall not administer antianxiety premedication in the practice of dentistry until they have complied with the provisions of rule 650—29.7(153).

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.3(153) Requirements for the issuance of deep sedation/general anesthesia permits.**

**29.3(1)** A permit may be issued to a licensed dentist to use deep sedation/general anesthesia on an outpatient basis for dental patients provided the dentist meets the following requirements:

- a. Has successfully completed an advanced education program accredited by the Commission on Dental Accreditation that provides training in deep sedation and general anesthesia; and
- b. Has formal training in airway management; and
- c. Has completed a minimum of one year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program approved by the board; and
- d. Has completed a peer review evaluation, as may be required by the board, prior to issuance of a permit.

**29.3(2)** A dentist using deep sedation/general anesthesia shall maintain a properly equipped facility at each facility where sedation is administered. The dentist shall maintain and be trained on the following equipment at each facility where sedation is provided: capnography, EKG monitor, positive pressure oxygen, suction, laryngoscope and blades, endotracheal tubes, magill forceps, oral airways, stethoscope, blood pressure monitoring device, pulse oximeter, emergency drugs, defibrillator. A licensee may submit a request to the board for an exemption from any of the provisions of this subrule. Exemption requests will be considered by the board on an individual basis and shall be granted only if the board determines that there is a reasonable basis for the exemption.

**29.3(3)** The dentist shall ensure that each facility where sedation services are provided is permanently equipped pursuant to subrule 29.3(2) and staffed with trained auxiliary personnel capable of reasonably handling procedures, problems and emergencies incident to the administration of general anesthesia. Auxiliary personnel shall maintain current certification in basic life support and be capable of administering basic life support.

**29.3(4)** A dentist administering deep sedation/general anesthesia must document and maintain current, successful completion of an Advanced Cardiac Life Support (ACLS) course.

**29.3(5)** A dentist who is performing a procedure for which deep sedation/general anesthesia was induced shall not administer the general anesthetic and monitor the patient without the presence and assistance of at least two qualified auxiliary personnel in the room who are qualified under subrule 29.3(3).

**29.3(6)** A dentist qualified to administer deep sedation/general anesthesia under this rule may administer moderate sedation and nitrous oxide inhalation analgesia provided the dentist meets the requirements of rule 650—29.6(153).

**29.3(7)** A licensed dentist who has been utilizing deep sedation/general anesthesia in a competent manner for the five-year period preceding July 9, 1986, but has not had the benefit of formal training as outlined in this rule, may apply for a permit provided the dentist fulfills the provisions set forth in 29.3(2), 29.3(3), 29.3(4), and 29.3(5).

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.4(153) Requirements for the issuance of moderate sedation permits.**

**29.4(1)** A permit may be issued to a licensed dentist to use moderate sedation for dental patients provided the dentist meets the following requirements:

- a. Has successfully completed a training program approved by the board that meets the American Dental Association Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students and that consists of a minimum of 60 hours of instruction and management of at least 20 patients; and

- b. Has formal training in airway management; or
- c. Has submitted evidence of successful completion of an accredited residency program that includes formal training and clinical experience in moderate sedation, which is approved by the board; and
- d. Has completed a peer review evaluation, as may be required by the board, prior to issuance of a permit.

**29.4(2)** A dentist utilizing moderate sedation shall maintain a properly equipped facility. The dentist shall maintain and be trained on the following equipment at each facility where sedation is provided: capnography or pretracheal/precordial stethoscope, EKG monitor, positive pressure oxygen, suction, laryngoscope and blades, endotracheal tubes, magill forceps, oral airways, stethoscope, blood pressure monitoring device, pulse oximeter, emergency drugs, defibrillator. A licensee may submit a request to the board for an exemption from any of the provisions of this subrule. Exemption requests will be considered by the board on an individual basis and shall be granted only if the board determines that there is a reasonable basis for the exemption.

**29.4(3)** The dentist shall ensure that each facility where sedation services are provided is permanently equipped pursuant to subrule 29.4(2) and staffed with trained auxiliary personnel capable of reasonably handling procedures, problems and emergencies incident to the administration of moderate sedation. Auxiliary personnel shall maintain current certification in basic life support and be capable of administering basic life support.

**29.4(4)** A dentist administering moderate sedation must document and maintain current, successful completion of an Advanced Cardiac Life Support (ACLS) course. A dentist administering moderate sedation to pediatric patients may maintain current certification in Pediatric Advanced Life Support (PALS) in lieu of ACLS.

**29.4(5)** A dentist who is performing a procedure for which moderate sedation is being employed shall not administer the pharmacologic agents and monitor the patient without the presence and assistance of at least one qualified auxiliary personnel in the room who is qualified under subrule 29.4(3).

**29.4(6)** Dentists qualified to administer moderate sedation may administer nitrous oxide inhalation analgesia provided they meet the requirement of rule 650—29.6(153).

**29.4(7)** If moderate sedation results in a general anesthetic state, the rules for deep sedation/general anesthesia apply.

**29.4(8)** A dentist utilizing moderate sedation on pediatric or ASA category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA category 3 or 4 patients. A dentist who does not meet the requirements of this subrule is prohibited from utilizing moderate sedation on pediatric or ASA category 3 or 4 patients.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13; ARC 1810C, IAB 1/7/15, effective 2/11/15]

### **650—29.5(153) Permit holders.**

**29.5(1)** No dentist shall use or permit the use of deep sedation/general anesthesia or moderate sedation for dental patients, unless the dentist possesses a current permit issued by the board. No dentist shall use or permit the use of deep sedation/general anesthesia or moderate sedation for dental patients in a facility that has not successfully passed an equipment inspection pursuant to the requirements of subrule 29.3(2). A dentist holding a permit shall be subject to review and facility inspection at a frequency described in subrule 29.5(10).

**29.5(2)** An application for a deep sedation/general anesthesia permit must include the appropriate fee as specified in 650—Chapter 15, as well as evidence indicating compliance with rule 650—29.3(153).

**29.5(3)** An application for a moderate sedation permit must include the appropriate fee as specified in 650—Chapter 15, as well as evidence indicating compliance with rule 650—29.4(153).

**29.5(4)** If a facility has not been previously inspected, no permit shall be issued until the facility has been inspected and successfully passed.

**29.5(5)** Permits shall be renewed biennially at the time of license renewal following submission of proper application and may involve board reevaluation of credentials, facilities, equipment, personnel, and procedures of a previously qualified dentist to determine if the dentist is still qualified. The appropriate fee for renewal as specified in 650—Chapter 15 of these rules must accompany the application.

**29.5(6)** Upon the recommendation of the anesthesia credentials committee that is based on the evaluation of credentials, facilities, equipment, personnel and procedures of a dentist, the board may determine that restrictions may be placed on a permit.

**29.5(7)** The actual costs associated with the on-site evaluation of the facility shall be the primary responsibility of the licensee. The cost to the licensee shall not exceed the fee as specified in 650—Chapter 15.

**29.5(8)** Permit holders shall follow the American Dental Association's guidelines for the use of sedation and general anesthesia for dentists, except as otherwise specified in these rules.

**29.5(9)** A dentist utilizing moderate sedation on pediatric or ASA category 3 or 4 patients must have completed an accredited residency program that includes formal training in anesthesia and clinical experience in managing pediatric or ASA category 3 or 4 patients. A dentist who does not meet the requirements of this subrule is prohibited from utilizing moderate sedation on pediatric or ASA category 3 or 4 patients.

**29.5(10)** Frequency of facility inspections.

*a.* The board office will conduct ongoing facility inspections of each facility every five years, with the exception of the University of Iowa College of Dentistry.

*b.* The University of Iowa College of Dentistry shall submit written verification to the board office every five years indicating that it is properly equipped pursuant to this chapter.

**29.5(11)** Use of capnography required beginning January 1, 2014. Consistent with the practices of the American Association of Oral and Maxillofacial Surgeons (AAOMS), all general anesthesia/deep sedation permit holders shall use capnography at all facilities where they provide sedation beginning January 1, 2014.

**29.5(12)** Use of capnography or pretracheal/precordial stethoscope required for moderate sedation permit holders. Beginning January 1, 2015, all moderate sedation permit holders shall use capnography or a pretracheal/precordial stethoscope at all facilities where they provide sedation.

[**ARC 8614B**, IAB 3/10/10, effective 4/14/10; **ARC 0265C**, IAB 8/8/12, effective 9/12/12; **ARC 1194C**, IAB 11/27/13, effective 11/4/13; **ARC 1810C**, IAB 1/7/15, effective 2/11/15]

#### **650—29.6(153) Nitrous oxide inhalation analgesia.**

**29.6(1)** A dentist may use nitrous oxide inhalation analgesia sedation on an outpatient basis for dental patients provided the dentist:

*a.* Has completed a board approved course of training; or

*b.* Has training equivalent to that required in 29.6(1) "a" while a student in an accredited school of dentistry, and

*c.* Has adequate equipment with fail-safe features and minimum oxygen flow which meets FDA standards.

*d.* Has routine inspection, calibration, and maintenance on equipment performed every two years and maintains documentation of such, and provides documentation to the board upon request.

*e.* Ensures the patient is continually monitored by qualified personnel while receiving nitrous oxide inhalation analgesia.

**29.6(2)** A dentist utilizing nitrous oxide inhalation analgesia shall be trained and capable of administering basic life support, as demonstrated by current certification in a nationally recognized course in cardiopulmonary resuscitation.

**29.6(3)** A licensed dentist who has been utilizing nitrous oxide inhalation analgesia in a dental office in a competent manner for the 12-month period preceding July 9, 1986, but has not had the benefit of formal training outlined in paragraph 29.6(1) "a" or 29.6(1) "b," may continue the use provided the dentist fulfills the requirements of paragraphs 29.6(1) "c" and "d" and subrule 29.6(2).

**29.6(4)** A dental hygienist may administer nitrous oxide inhalation analgesia provided the administration of nitrous oxide inhalation analgesia has been delegated by a dentist and the hygienist meets the following qualifications:

- a. Has completed a board-approved course of training; or
- b. Has training equivalent to that required in 29.6(4) “a” while a student in an accredited school of dental hygiene.

**29.6(5)** A dental hygienist or registered dental assistant may monitor a patient under nitrous oxide inhalation analgesia provided all of the following requirements are met:

- a. The hygienist or registered dental assistant has completed a board-approved course of training or has received equivalent training while a student in an accredited school of dental hygiene or dental assisting;
- b. The task has been delegated by a dentist and is performed under the direct supervision of a dentist;
- c. Any adverse reactions are reported to the supervising dentist immediately; and
- d. The dentist dismisses the patient following completion of the procedure.

**29.6(6)** A dentist who delegates the administration of nitrous oxide inhalation analgesia in accordance with 29.6(4) shall provide direct supervision and establish a written office protocol for taking vital signs, adjusting anesthetic concentrations, and addressing emergency situations that may arise.

**29.6(7)** If the dentist intends to achieve a state of moderate sedation from the administration of nitrous oxide inhalation analgesia, the rules for moderate sedation apply.  
[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 8614B, IAB 3/10/10, effective 4/14/10]

#### **650—29.7(153) Minimal sedation.**

**29.7(1)** The term “minimal sedation” also means “antianxiety premedication” or “anxiolysis.”

**29.7(2)** If a dentist intends to achieve a state of moderate sedation from the administration of minimal sedation, the rules for moderate sedation shall apply.

**29.7(3)** A dentist utilizing minimal sedation and the dentist’s auxiliary personnel shall be trained in and capable of administering basic life support.

**29.7(4)** Minimal sedation for adults.

a. Minimal sedation for adults is limited to a dentist’s prescribing or administering a single enteral drug that is no more than 1.0 times the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use. A single supplemental dose of the same drug may be administered, provided the supplemental dose is no more than one-half of the initial dose and the dentist does not administer the supplemental dose until the dentist has determined the clinical half-life of the initial dose has passed.

b. The total aggregate dose shall not exceed 1.5 times the MRD on the day of treatment.

c. For adult patients, a dentist may also utilize nitrous oxide inhalation analgesia in combination with a single enteral drug.

d. Combining two or more enteral drugs, excluding nitrous oxide, prescribing or administering drugs that are not recommended for unmonitored home use, or administering any intravenous drug constitutes moderate sedation and requires that the dentist must hold a moderate sedation permit.

**29.7(5)** Minimal sedation for ASA category 3 or 4 patients or pediatric patients.

a. Minimal sedation for ASA category 3 or 4 patients or pediatric patients is limited to a dentist’s prescribing or administering a single dose of a single enteral drug that can be prescribed for unmonitored home use and that is no more than 1.0 times the maximum recommended dose.

b. A dentist may administer nitrous oxide inhalation analgesia for minimal sedation of ASA category 3 or 4 patients or pediatric patients provided the concentration does not exceed 50 percent and is not used in combination with any other drug.

c. The use of one or more enteral drugs in combination with nitrous oxide, the use of more than a single enteral drug, or the administration of any intravenous drug in ASA category 3 or 4 patients

or pediatric patients constitutes moderate sedation and requires that the dentist must hold a moderate sedation permit.

**29.7(6)** A dentist providing minimal sedation shall not bill for non-IV conscious or moderate sedation.

**29.7(7)** A dentist shall ensure that any advertisements related to the availability of antianxiety premedication, anxiolysis, or minimal sedation clearly reflect the level of sedation provided and are not misleading.

[ARC 8614B, IAB 3/10/10, effective 4/14/10]

**650—29.8(153) Noncompliance.** Violations of the provisions of this chapter may result in revocation or suspension of the dentist's permit or other disciplinary measures as deemed appropriate by the board.

**650—29.9(153) Reporting of adverse occurrences related to sedation, nitrous oxide inhalation analgesia, and antianxiety premedication.**

**29.9(1) Reporting.** All licensed dentists in the practice of dentistry in this state must submit a report within a period of seven days to the board office of any mortality or other incident which results in temporary or permanent physical or mental injury requiring hospitalization of the patient during, or as a result of, antianxiety premedication, nitrous oxide inhalation analgesia, or sedation. The report shall include responses to at least the following:

- a. Description of dental procedure.
- b. Description of preoperative physical condition of patient.
- c. List of drugs and dosage administered.
- d. Description, in detail, of techniques utilized in administering the drugs utilized.
- e. Description of adverse occurrence:
  1. Description, in detail, of symptoms of any complications, to include but not be limited to onset, and type of symptoms in patient.
  2. Treatment instituted on the patient.
  3. Response of the patient to the treatment.
- f. Description of the patient's condition on termination of any procedures undertaken.

**29.9(2) Failure to report.** Failure to comply with subrule 29.9(1), when the occurrence is related to the use of sedation, nitrous oxide inhalation analgesia, or antianxiety premedication, may result in the dentist's loss of authorization to administer sedation, nitrous oxide inhalation analgesia, or antianxiety premedication or in any other sanction provided by law.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.10(153) Anesthesia credentials committee.**

**29.10(1)** The anesthesia credentials committee is a peer review committee appointed by the board to assist the board in the administration of this chapter. This committee shall be chaired by a member of the board and shall include at least six additional members who are licensed to practice dentistry in Iowa. At least four members of the committee shall hold deep sedation/general anesthesia or moderate sedation permits issued under this chapter.

**29.10(2)** The anesthesia credentials committee shall perform the following duties at the request of the board:

- a. Review all permit applications and make recommendations to the board regarding those applications.
- b. Conduct site visits at facilities under rule 650—29.5(153) and report the results of those site visits to the board. The anesthesia credentials committee may submit recommendations to the board regarding the appropriate nature and frequency of site visits.
- c. Perform professional evaluations and report the results of those evaluations to the board.
- d. Other duties as delegated by the board or board chairperson.

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.11(153) Review of permit applications.**

**29.11(1)** *Review by board staff.* Upon receipt of a completed application, board staff will review the application for eligibility. Following staff review, a public meeting of the ACC will be scheduled.

**29.11(2)** *Review by the anesthesia credentials committee (ACC).* Following review and consideration of an application, the ACC may at its discretion:

- a. Request additional information;
  - b. Request an investigation;
  - c. Request that the applicant appear for an interview;
  - d. Recommend issuance of the permit;
  - e. Recommend issuance of the permit under certain terms and conditions or with certain restrictions;
  - f. Recommend denial of the permit;
  - g. Refer the permit application to the board for review and consideration without recommendation;
- or
- h. Request a peer review evaluation.

**29.11(3)** *Review by executive director.* If, following review and consideration of an application, the ACC recommends issuance of the permit with no restrictions or conditions, the executive director as authorized by the board has discretion to authorize the issuance of the permit.

**29.11(4)** *Review by board.* The board shall consider applications and recommendations from the ACC. The board may take any of the following actions:

- a. Request additional information;
- b. Request an investigation;
- c. Request that the applicant appear for an interview;
- d. Grant the permit;
- e. Grant the permit under certain terms and conditions or with certain restrictions; or
- f. Deny the permit.

**29.11(5)** *Right to defer final action.* The ACC or board may defer final action on an application if there is an investigation or disciplinary action pending against an applicant who may otherwise meet the requirements for permit until such time as the ACC or board is satisfied that issuance of a permit to the applicant poses no risk to the health and safety of Iowans.

**29.11(6)** *Appeal process for denials.* If a permit application is denied, an applicant may file an appeal of the final decision using the process described in rule 650—11.10(147).

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.12(153) Renewal.** A permit to administer deep sedation/general anesthesia or moderate sedation shall be renewed biennially at the time of license renewal. Permits expire August 31 of every even-numbered year.

**29.12(1)** To renew a permit, a licensee must submit the following:

- a. Evidence of renewal of ACLS certification.
- b. A minimum of six hours of continuing education in the area of sedation. These hours may also be submitted as part of license renewal requirements.
- c. The appropriate fee for renewal as specified in 650—Chapter 15.

**29.12(2)** Failure to renew the permit prior to November 1 following its expiration shall cause the permit to lapse and become invalid for practice.

**29.12(3)** A permit that has been lapsed may be reinstated upon submission of a new application for a permit in compliance with rule 650—29.5(153) and payment of the application fee as specified in 650—Chapter 15.

[ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.13(147,153,272C) Grounds for nonrenewal.** A request to renew a permit may be denied on any of the following grounds:

**29.13(1)** After proper notice and hearing, for a violation of these rules or Iowa Code chapter 147, 153, or 272C during the term of the last permit renewal.

**29.13(2)** Failure to pay required fees.

**29.13(3)** Failure to obtain required continuing education.

**29.13(4)** Failure to provide documentation of current ACLS certification.

**29.13(5)** Failure to provide documentation of maintaining a properly equipped facility.

**29.13(6)** Receipt of a certificate of noncompliance from the college student aid commission or the child support recovery unit of the department of human services in accordance with 650—Chapter 33 or 650—Chapter 34.

[ARC 1194C, IAB 11/27/13, effective 11/4/13]

**650—29.14(153) Record keeping.**

**29.14(1)** *Minimal sedation.* An appropriate sedative record must be maintained and must contain the names of all drugs administered, including local anesthetics and nitrous oxide, dosages, time administered, and monitored physiological parameters, including oxygenation, ventilation, and circulation.

**29.14(2)** *Moderate or deep sedation.* The patient chart must include preoperative and postoperative vital signs, drugs administered, dosage administered, anesthesia time in minutes, and monitors used. Pulse oximetry, heart rate, respiratory rate, and blood pressure must be recorded continually until the patient is fully ambulatory. The chart should contain the name of the person to whom the patient was discharged.

**29.14(3)** *Nitrous oxide inhalation analgesia.* The patient chart must include the concentration administered and duration of administration, as well as any vital signs taken.

[ARC 8369B, IAB 12/16/09, effective 1/20/10; ARC 8614B, IAB 3/10/10, effective 4/14/10; ARC 1194C, IAB 11/27/13, effective 11/4/13]

These rules are intended to implement Iowa Code sections 153.33 and 153.34.

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[Filed ARC 1810C (Notice ARC 1658C, IAB 10/1/14), IAB 1/7/15, effective 2/11/15]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date of 29.6(4) to 29.6(6) delayed 70 days by the Administrative Rules Review Committee at its meeting held June 9, 1998.

<sup>2</sup> Effective date of 29.6(4) to 29.6(6) delayed until the end of the 2000 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held September 15, 1999. Subrules 29.6(4) and 29.6(5) were rescinded IAB 2/9/00, effective 3/15/00; delay on subrule 29.6(6) lifted by the Administrative Rules Review Committee at its meeting held January 4, 2000, effective January 5, 2000.

CHAPTER 52  
MILITARY SERVICE AND VETERAN RECIPROCITY

**650—52.1(85GA,ch1116) Definitions.**

“*License*” or “*licensure*” means any license, registration, certificate or permit that may be granted by the board.

“*Military service*” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

“*Military service applicant*” means an individual who is requesting credit toward licensure for military education, training, or service obtained or completed in military service.

“*Reciprocity*” means the process by which an individual licensed in another jurisdiction becomes licensed in Iowa and may also be referred to in other board rules as “licensure by credentials.”

“*Veteran*” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2).  
[ARC 1811C, IAB 1/7/15, effective 2/11/15]

**650—52.2(85GA,ch1116) Military education, training, and service credit.** A military service applicant may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting a military service application form to the board office.

**52.2(1)** The completed military service application may be submitted with an application for licensure or examination or prior to an applicant’s applying for licensure or to take an examination. No fee is required with submission of an application for military service credit.

**52.2(2)** The applicant shall identify the experience or educational licensure requirement to which the credit would be applied if granted. Credit shall not be applied to an examination requirement.

**52.2(3)** The applicant shall provide documents, military transcripts, a certified affidavit, or forms that verify completion of the relevant military education, training, or service, which may include, when applicable, the applicant’s Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET) (DD Form 2586).

**52.2(4)** Upon receipt of a completed military service application, the board shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational licensure requirement.

**52.2(5)** The board shall grant the application in whole or in part if the board determines that the verified military education, training, or service satisfies all or part of the experience or educational qualifications for licensure.

**52.2(6)** The board shall inform the military service applicant in writing of the credit, if any, given toward an experience or educational qualification for licensure or explain why no credit was granted. The applicant may request reconsideration upon submission of additional documentation or information.

**52.2(7)** A military service applicant who is aggrieved by the board’s decision may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board’s decision. No fees or costs shall be assessed against the military service applicant in connection with a contested case conducted pursuant to this subrule.

**52.2(8)** The board shall grant or deny the military service application prior to ruling on the application for licensure. The applicant shall not be required to submit any fees in connection with the licensure application unless the board grants the military service application. If the board does not grant the military service application, the applicant may withdraw the licensure application or request that the licensure application be placed in pending status for up to one year or as mutually agreed. The withdrawal of a licensure application shall not preclude subsequent applications supported by additional documentation or information.

[ARC 1811C, IAB 1/7/15, effective 2/11/15]

**650—52.3(85GA,ch1116) Veteran reciprocity.**

**52.3(1)** A veteran with an unrestricted professional license in another jurisdiction may apply for licensure in Iowa through reciprocity. A veteran must pass any examinations required for licensure to be eligible for licensure through reciprocity. A fully completed application for licensure submitted by a veteran under this subrule shall be given priority and shall be expedited.

**52.3(2)** An application for licensure by reciprocity shall contain all of the information required of all applicants for licensure who hold unrestricted licenses in other jurisdictions and who are applying for licensure by reciprocity including, but not limited to, completion of all required forms, payment of applicable fees, disclosure of criminal or disciplinary history, and, if applicable, a criminal history background check. The applicant shall use the same forms as any other applicant for licensure by reciprocity and shall additionally provide such documentation as is reasonably needed to verify the applicant's status as a veteran under Iowa Code section 35.1(2).

**52.3(3)** Upon receipt of a fully completed licensure application, the board shall promptly determine if the professional or occupational licensing requirements of the jurisdiction where the veteran is licensed are substantially equivalent to the licensing requirements in Iowa. The board shall make this determination based on information supplied by the applicant and such additional information as the board may acquire from the applicable jurisdiction. The board may consider the following factors in determining substantial equivalence: scope of practice, education and coursework, degree requirements, postgraduate experience, and examinations required for licensure.

**52.3(4)** The board shall promptly grant a license to the veteran if the veteran is licensed in the same or similar profession in another jurisdiction whose licensure requirements are substantially equivalent to those required in Iowa, unless the applicant is ineligible for licensure based on other grounds, for example, the applicant's disciplinary or criminal background.

**52.3(5)** If the board determines that the licensure requirements in the jurisdiction in which the veteran is licensed are not substantially equivalent to those required in Iowa, the board shall promptly inform the veteran of the additional experience, education, or examinations required for licensure in Iowa. Unless the applicant is ineligible for licensure based on other grounds, such as disciplinary or criminal background, the following shall apply:

*a.* If a veteran has not passed the required examination(s) for licensure, the veteran may not be issued a provisional license, but may request that the licensure application be placed in pending status for up to one year or as mutually agreed to provide the veteran with the opportunity to satisfy the examination requirements.

*b.* If additional experience or education is required in order for the applicant's qualifications to be considered substantially equivalent, the applicant may request that the board issue a provisional license for a specified period of time during which the applicant will successfully complete the necessary experience or education. The board shall issue a provisional license for a specified period of time upon such conditions as the board deems reasonably necessary to protect the health, welfare or safety of the public unless the board determines that the deficiency is of a character that the public health, welfare or safety will be adversely affected if a provisional license is granted.

*c.* If a request for a provisional license is denied, the board shall issue an order fully explaining the decision and shall inform the applicant of the steps the applicant may take in order to receive a provisional license.

*d.* If a provisional license is issued, the application for full licensure shall be placed in pending status until the necessary experience or education has been successfully completed or the provisional license expires, whichever occurs first. The board may extend a provisional license on a case-by-case basis for good cause.

**52.3(6)** A veteran who is aggrieved by the board's decision to deny an application for a reciprocal license or a provisional license or is aggrieved by the terms under which a provisional license will be granted may request a contested case (administrative hearing) and may participate in a contested case by telephone. A request for a contested case shall be made within 30 days of issuance of the board's

decision. No fees or costs shall be assessed against the veteran in connection with a contested case conducted pursuant to this subrule.

[ARC 1811C, IAB 1/7/15, effective 2/11/15]

These rules are intended to implement 2014 Iowa Acts, chapter 1116, division VI.

[Filed ARC 1811C (Notice ARC 1645C, IAB 10/1/14), IAB 1/7/15, effective 2/11/15]



## **NURSING BOARD[655]**

[Prior to 8/26/87, see Nursing, Board of[590], renamed Nursing Board[655]  
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CHAPTER 3  
LICENSURE TO PRACTICE—REGISTERED NURSE/LICENSED PRACTICAL NURSE

**655—3.1(17A,147,152,272C) Definitions.**

*“Accredited or approved nursing program”* means a nursing education program whose status has been recognized by the board or by a similar board in another jurisdiction that prepares individuals for licensure as a licensed practical nurse, registered nurse, or advanced registered nurse practitioner; or grants a baccalaureate, master’s or doctorate degree with a major in nursing.

*“Address”* means a street address in any state when a street address is available or a rural route address when a street address is not available.

*“Applicant”* means a person who is qualified to take the examination or apply for licensure by endorsement.

*“Endorsement”* means the process by which a registered nurse/licensed practical nurse licensed in another jurisdiction becomes licensed in Iowa.

*“Examination”* means the tests used to determine minimum competency prior to the issuance of a registered nurse/licensed practical nurse license.

*“Fees”* means those fees collected which are based upon the cost of sustaining the board’s mission to protect the public health, safety and welfare. The nonrefundable fees set by the board are as follows:

1. Application for original license based on the registered nurse examination, \$93 (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI)).
2. Application for original license based on the practical nurse examination, \$93 (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the DCI and the FBI).
3. Application for registered nurse/licensed practical nurse license by endorsement, \$119 (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the DCI and the FBI).
4. Application for original license or renewal as an advanced registered nurse practitioner, \$81 for any period of licensure up to three years.
5. For a certified statement that a registered nurse/licensed practical nurse is licensed in this state or registered as an advanced registered nurse practitioner, \$25.
6. For written verification of licensure status, not requiring certified statements, \$3 per license.
7. For reactivation of a license to practice as a registered nurse/licensed practical nurse, \$175 for a license lasting more than 24 months up to 36 months (plus the fee for evaluation of the fingerprint cards and the criminal history background checks by the DCI and the FBI).
8. For reactivation of a license to practice as an advanced registered nurse practitioner, \$81 for any period of licensure up to three years.
9. For the renewal of a license to practice as a registered nurse/licensed practical nurse, \$99 for a three-year period.
10. For a duplicate or reissued wallet card or original certificate to practice as a registered nurse, licensed practical nurse, or advanced registered nurse practitioner, \$20.
11. For late renewal of a registered nurse/licensed practical nurse license, \$50, plus the renewal fee as specified in paragraph “9” of this definition.
12. For a check returned for any reason, \$15. If licensure/registration has been issued by the board office based on a check for the payment of fees and the check is later returned by the bank, the board shall request payment by certified check or money order.
13. For a certified copy of an original document, \$20.
14. For special licensure, \$62.
15. For the evaluation of the fingerprint cards and the DCI and FBI criminal history background checks, \$50.

*“Inactive license”* means a registered nurse or licensed practical nurse license that has been placed on inactive status because it was not renewed by the fifteenth day of the month following the expiration date, or the board has received notification that a licensee has declared another compact state as primary

state of residency. Pursuant to 655—subrule 16.2(8), the former home state license shall no longer be valid upon the issuance of a new home state license.

“*Late license*” means a registered nurse or licensed practical nurse license that has not been renewed by the expiration date on the wallet card. The time between the expiration date and the fifteenth day of the month following the expiration date is considered a grace period.

“*Licensee*” means a person who has been issued a license to practice as a registered nurse, licensed practical nurse or advanced registered nurse practitioner under the laws of this state.

“*NCLEX®*” means National Council Licensure Examination for registered nurse/licensed practical nurse licensure.

“*Overpayment*” means payment in excess of the required fee. Overpayment less than \$10 received by the board shall not be refunded.

“*Reactivation*” means the process whereby an inactive licensee obtains a current license.

“*Reinstatement*,” pursuant to rule 655—4.11(17A,147,152,272C), means the process by which any person whose license to practice nursing has been suspended, revoked or voluntarily surrendered by order of the board may apply for license consideration.

“*Temporary license*” means a license issued on a short-term basis for a specified time pursuant to subrule 3.5(4).

“*Unlicensed student*” means a person enrolled in a nursing education program who has never been licensed as a registered nurse or licensed practical/vocational nurse in any U.S. jurisdiction.

“*Verification*” means the process whereby the board provides a certified statement that the license of a registered nurse/licensed practical nurse/advanced registered nurse practitioner is active, inactive, or encumbered/disciplined.

This rule is intended to implement Iowa Code sections 147.80 and 147.82.

[ARC 1130C, IAB 10/30/13, effective 12/4/13; ARC 1815C, IAB 1/7/15, effective 2/11/15]

### **655—3.2(17A,147,152,272C) Mandatory licensure.**

**3.2(1)** A person who practices nursing in the state of Iowa as defined in Iowa Code section 152.1, outside of one’s family, shall have a current Iowa license, whether or not the employer is in Iowa and whether or not the person receives compensation. Any nurse who participates in the care of a patient situated in Iowa, whether that care is provided through telephonic, electronic or in-person means, and regardless of the location of the nurse, must obtain Iowa licensure unless specifically exempted by the licensure compact agreement. The nurse shall maintain verification of licensure and shall have it available for inspection when engaged in the practice of nursing in Iowa.

**3.2(2)** Current Iowa licensure is not mandatory when:

*a.* A nurse who resides in another party state is recognized for licensure in this state pursuant to the nurse licensure compact contained in Iowa Code chapter 152E. The nurse shall maintain verification of licensure and shall have it available for inspection when engaged in the practice of nursing in Iowa.

*b.* A nurse who holds an active license in another state provides services to patients in Iowa only during interstate transit.

*c.* A nurse who holds an active license in another state provides emergency services in an area in which the governor of Iowa has declared a state of emergency.

**3.2(3)** A nurse who is enrolled in an approved nursing program shall hold an active license in the U.S. jurisdiction(s) in which the nurse provides patient care.

This rule is intended to implement Iowa Code section 147.2.

[ARC 1815C, IAB 1/7/15, effective 2/11/15]

### **655—3.3(17A,147,152,272C) Licensure qualifications for registered nurse and licensed practical nurse.**

**3.3(1)** Applicants shall meet the requirements set forth in Iowa Code sections 147.3 and 152.7. Requirements include:

*a.* Graduation from an approved nursing program preparing registered nurses as defined in Iowa Code section 152.5(1) for registered nurse applicants or graduation from an approved nursing

program preparing practical nurses as defined in Iowa Code section 152.5(1) for licensed practical nurse applicants.

*b.* Passing NCLEX® or the State Board Test Pool Examination, the national examination used prior to 1982.

*c.* Board approval of an applicant with a criminal history or a record of prior disciplinary action, regardless of jurisdiction.

**3.3(2)** The requirement listed in paragraph 3.3(1) “*b*” is subject to the following exceptions:

*a.* A practical nurse applicant must have written the same examination as that administered in Iowa and achieved a score established as passing for that test by the board unless the applicant graduated and was licensed prior to July 1951.

*b.* An applicant whose national examination scores do not meet the Iowa requirements in effect at the time of the examination and who wishes to become licensed in Iowa may appeal to the board. The board may require the applicant to pass the current examination.

This rule is intended to implement Iowa Code sections 147.2 and 152.7(3).

[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.4(17A,147,152,272C) Licensure by examination.**

**3.4(1)** Applicants shall meet qualifications for licensure set forth in subrule 3.3(1).

**3.4(2)** The board contracts with the National Council of State Boards of Nursing, Inc. to use the NCLEX® for registered nurses and licensed practical nurses.

*a.* The NCLEX® is administered according to guidelines and passing standards established by the National Council of State Boards of Nursing, Inc.

*b.* NCLEX® results are reported as pass or fail.

*c.* Examination statistics are available to the public.

**3.4(3)** Application—graduates of approved programs.

*a.* The board shall:

(1) Provide information about licensure application to applicants, nursing education programs in Iowa, and others upon request.

(2) Determine eligibility of each applicant upon receipt of an application, fees, official nursing transcript, fingerprint cards and a signed waiver form.

*b.* The applicant shall:

(1) Submit a completed application for license by examination.

(2) Submit two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint cards and the DCI and FBI criminal history background checks will be assessed to the applicant.

(3) Submit fee for application for license by examination plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.

(4) Register for the NCLEX® and submit registration fee to the national test service agency.

(5) Direct the nursing program to submit to the board an official nursing transcript denoting the date of graduation and diploma or degree conferred.

(6) Inform the board that the primary state of residence is Iowa or a noncompact state and provide a current street address and mailing address, if different.

(7) Submit a copy of the court document(s) with the license application if the applicant has a criminal history.

(8) Complete NCLEX® registration through the national test service agency within 12 months of board receipt of the application for license, fingerprint cards, signed waiver form, and fees. The board reserves the right to destroy documents after 12 months.

(9) Self-schedule the examination with an approved testing center.

(10) Applicants who do not test within 91 days of authorization from the national test service agency are required to submit a new application and fee to the board.

**3.4(4)** Application—individuals educated and licensed in another country.

- a.* The board shall:
- (1) Provide information about licensure application to applicants and others upon request.
  - (2) Determine eligibility of each applicant upon receipt of:
    1. Application for license by examination.
    2. Two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check.
    3. Application fee for license by examination plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.
    4. Official nursing transcript denoting date of graduation validated by the Commission on Graduates of Foreign Nursing Schools (CGFNS) International.
    5. Validation of licensure/registration in the original country by CGFNS International.
    6. Credentials Evaluation Service Professional report submitted by CGFNS International for licensed practical nurse and registered nurse applicants.
    7. Verification of ability to read, write, speak and understand the English language as determined by the results of the International English Language Testing System (IELTS), Pearson Test of English Academic (PTE), or Test of English as a Foreign Language (TOEFL) for licensed practical nurse and registered nurse applicants. Applicants shall be exempt from the IELTS, PTE or TOEFL examination when the native language is English; nursing education was completed in a college, university or professional school located in Australia, Barbados, Canada (except Quebec), Ireland, Jamaica, New Zealand, South Africa, Trinidad and Tobago, or the United Kingdom; language of instruction in the nursing program was English; and language of the textbooks in the nursing program was English.
- b.* The applicant shall:
- (1) Submit completed application for license by examination, including two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check.
  - (2) Submit fee for application for license by examination plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.
  - (3) Register for the NCLEX® and submit registration fee to the national test service agency.
  - (4) Direct CGFNS International to validate the official nursing transcript.
  - (5) Direct CGFNS International to validate licensure/registration in the original country.
  - (6) Complete the Credentials Evaluation Service Professional report application through CGFNS International for licensed practical nurse and registered nurse applicants.
  - (7) Complete IELTS, PTE or TOEFL requirements for licensed practical nurse and registered nurse applicants, unless exempt.
  - (8) Inform the board of primary state of residence and a current street address and mailing address, if different.
  - (9) Submit a copy of the court document(s) with the license application if the applicant has a criminal history.
  - (10) Self-schedule the examination with an approved testing center.
  - (11) Complete NCLEX® registration through the national test service agency within 12 months of board receipt of the application for license, fingerprint cards, signed waiver form, and fees. The board reserves the right to destroy documents after 12 months.
  - (12) Applicants who do not test within 91 days of authorization from the national test service agency are required to submit a new application and fee to the board.
- 3.4(5) Application—individuals with disabilities.** Individuals with disabilities as defined in the Americans with Disabilities Act shall be provided modifications during the NCLEX®.
- a.* The board shall:
- (1) Notify applicants of the availability of test modifications for individuals with documented disabilities.
  - (2) Upon request, notify applicants of the process for obtaining board approval of test modification as defined in paragraph 3.4(5) “*b.*”

- (3) Determine eligibility for test modification upon receipt of:
  1. Written request from the applicant for test modifications during the NCLEX®.
  2. Written documentation of the applicant's disability and need for test modifications, including results of appropriate diagnostic testing, submitted by a qualified professional with expertise in the area of the diagnosed disability.
  3. Written documentation of test modifications, if any, granted to the applicant while enrolled in the nursing education program.
    - b. The applicant shall:
      - (1) Submit to the board a written request for specific modifications during the NCLEX®.
      - (2) Obtain appropriate documentation supporting the request for accommodations, including results of appropriate diagnostic testing, submitted by a qualified professional with expertise in the areas of the diagnosed disability. Documentation could include recent reports, test results, evaluations and assessments of the candidate's need for accommodations due to a disability (physical or mental impairment) that substantially limits one or more major life activities.
      - (3) Direct the nursing program to submit to the board documentation of test modifications provided to the applicant while enrolled in the nursing education program, if any were granted.
      - (4) Complete examination application requirements defined in subrule 3.4(3) or 3.4(4).

**3.4(6) Reexamination.**

- a. An applicant who has graduated from an approved practical nurse program and has failed the NCLEX-PN® is eligible to take the NCLEX-PN® an indefinite number of times.
- b. An applicant who has graduated from an approved registered nurse program and has failed the NCLEX-RN® is eligible to take the NCLEX-RN® an indefinite number of times.
- c. An applicant who fails the NCLEX® and reapplies within 12 months for license by examination shall be required to complete an application for license by examination, submit the fee for application by examination, complete NCLEX® registration and submit a registration fee to the national test service agency.
- d. An applicant who fails the NCLEX® and reapplies, after 12 months have passed, for license by examination shall be required to complete an application for license by examination, submit two completed fingerprint cards, a signed waiver form, and the fee for evaluation of the fingerprint cards and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI), pursuant to rule 655—3.1(17A,147,152,272C), complete NCLEX® registration and submit a registration fee to the national test service agency.
- e. Applicants for the examination who do not appear for the appointment or do not complete the examination will be required to complete the examination requirements defined in paragraphs 3.4(6) "a" to "d."

**3.4(7) Certificate of license by examination.** Upon completion of the relevant qualifications for license by examination and passing of the NCLEX® as defined in these rules, the board shall issue a certificate of license by examination and a current license to practice as a registered nurse/licensed practical nurse. The board staff may issue a certificate of license prior to receipt of a report on the applicant from the DCI/FBI.

This rule is intended to implement Iowa Code sections 147.36, 147.80 and 152.7(3).  
[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 8810B, IAB 6/2/10, effective 7/7/10; ARC 1131C, IAB 10/30/13, effective 12/4/13; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.5(17A,147,152,272C) Licensure by endorsement.**

**3.5(1) Qualifications for licensure by endorsement.** The endorsee shall meet the qualifications for licensure defined in subrule 3.3(1).

**3.5(2) Applicants currently licensed in another state.** Application for licensure to practice as a registered nurse or licensed practical nurse by endorsement shall be made according to the following process:

- a. The board shall:
  - (1) Provide application forms and instructions to applicants upon request.

(2) Determine eligibility of each applicant upon receipt of an application, fees, official nursing transcript, and verification of license submitted by state of original license or the National Council of State Boards of Nursing, Inc., electronic nurse licensure system (NURSYS®).

*b.* The applicant shall:

(1) Submit a completed application form for license by endorsement.

(2) Submit two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint cards and the DCI and FBI criminal history background checks will be assessed to the applicant.

(3) Submit the fee for license by endorsement plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.

(4) Direct the nursing program to submit to the board an official nursing transcript denoting the date of graduation and diploma or degree conferred.

(5) Provide verification of state of original licensure by one of the following:

1. Submit the application form for verification of original licensure to state of original licensure.

2. Apply directly to the online verification system (NURSYS®) if the original state of licensure participates in NURSYS®.

(6) Attest that Iowa is the primary state of residence if the applicant is changing primary state of residence from another party state as outlined in rule 655—16.2(152E) or that the primary state of residence is a noncompact state. The board may request evidence of residency.

(7) Complete the application process within 12 months from the date of receipt of the application. The board reserves the right to destroy the documents after 12 months.

*c.* An endorsement applicant who has been disciplined by a licensing authority in another state must indicate the jurisdiction of the action(s) when submitting application materials. A copy of all relevant disciplinary documents will be obtained for board review prior to a determination regarding licensure. The board may impose conditions for licensure.

*d.* An endorsement applicant who has a criminal history must submit a copy of the court document(s) when submitting application materials. The board may impose conditions for licensure.

*e.* An applicant who fails to complete the licensure process within 12 months from the date of receipt of the application must reapply.

**3.5(3)** *Application—individuals educated and licensed in another country.*

*a.* The board shall:

(1) Provide application forms and instructions to applicants upon request.

(2) Determine eligibility of each applicant upon receipt of an application, two completed fingerprint cards and a signed waiver form, fees, official nursing transcript denoting date of graduation validated by CGFNS International, validation of licensure/registration in the original country by CGFNS International, Credentials Evaluation Service Professional report from CGFNS International, and verification of original license submitted by state of original license or the National Council of State Boards of Nursing, Inc., electronic nurse licensure system (NURSYS®).

*b.* The applicant shall:

(1) Submit completed application for licensure by endorsement, including two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check.

(2) Submit fee for application for licensure by endorsement plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C). All fees are nonrefundable.

(3) Direct CGFNS International to validate the official nursing transcript.

(4) Direct CGFNS International to validate licensure/registration in the original country.

(5) Complete the Credentials Evaluation Service Professional report application through CGFNS International for licensed practical nurse and registered nurse applicants, or direct CGFNS International to verify that a certificate letter was issued, or send the completed Credentials Evaluation Service Professional report to the board.

(6) Inform the board of primary state of residence and a current street address and mailing address, if different.

(7) Submit a copy of the court document(s) with the license application if an applicant has a criminal history.

**3.5(4) *Temporary license.*** A temporary license shall be issued to an applicant who is licensed in another state if the applicant meets the qualifications for a license as outlined in subrule 3.3(1). The application form and endorsement fee plus the fee for evaluation of the fingerprint cards and the criminal history background checks as identified in the definition of “fees” in rule 655—3.1(17A,147,152,272C), verification of license form and two completed fingerprint cards and signed waiver form to facilitate a national criminal history background check shall be on file in the office of the board prior to the issuance of the temporary license.

a. A temporary licensee may use the appropriate title of registered nurse or licensed practical nurse and the appropriate abbreviation R.N. or L.P.N.

b. The temporary wallet card must be signed by the licensee to be valid. The temporary license shall be issued for a period of 30 days. A second temporary license may be issued for a period not to exceed 30 days or at the discretion of the executive director.

c. A temporary license may be issued to an applicant who has incurred disciplinary action in another state when the license is not currently encumbered.

d. A temporary license may not be issued to an applicant with a criminal history.

e. A temporary license shall not be issued to an applicant educated and licensed in another country until the Credentials Evaluation Service Professional report application through CGFNS International has been received by the board, CGFNS International has verified that a certificate letter was issued, or CGFNS International submits a previously completed Credentials Evaluation Service Professional report to the board.

**3.5(5) *Certificate of license by endorsement.*** Upon completion of the endorsement procedures defined in these rules, the board shall issue a certificate of license by endorsement and a current license to practice as a registered nurse/licensed practical nurse. The board staff may issue a certificate of license prior to receipt of a report on the applicant from the DCI/FBI.

This rule is intended to implement Iowa Code sections 147.2 and 152.9.  
[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 8810B, IAB 6/2/10, effective 7/7/10; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.6(17A,147,152,272C) *Special licensure for those licensed in another country.*** A special license may be granted by the board on an individual basis to allow a nurse licensed in another country who is not eligible for endorsement to practice nursing in Iowa for a fixed period of time under certain conditions. Special licensure shall allow the nurse to provide care in a specialty area, provide consultation or teaching where care is directed, serve as a research or teaching assistant, or obtain clinically based continuing education.

1. Upon request, the board shall provide application materials to the applicant or sponsor.

2. The applicant shall provide identifying information, criminal history, history of licensure in another jurisdiction, and reason for special licensure.

3. The applicant shall complete the application, submit a fee as identified in rule 655—3.1(17A,147,152,272C), and provide evidence of certification by CGFNS International, official results of the TOEFL test or official results of the International English Language Testing System (IELTS). The applicant shall have a minimum score of 540 for the paper-based TOEFL test, a minimum score of 207 for the computer-based TOEFL test, or a minimum score of 83 for the Internet-based TOEFL test. The applicant shall score a minimum of 6.5 for the IELTS test.

4. Board staff shall determine the validity of the request based on the need, duration and location of special licensure identified on the application, and staff shall notify the applicant of ineligibility for special licensure if the application is incomplete or indicates a criminal history or evidence of licensure in another jurisdiction.

5. The board shall grant special licensure to eligible applicants. The license shall be identified as a special license and identify duration and conditions as designated in this rule. The period of special licensure shall be determined by the board and may be extended at the request of the applicant.

6. If the board denies special licensure, the individual may be eligible for licensure by examination in accordance with subrule 3.4(4).

7. The licensee shall be subject to all rules and regulations promulgated by the board except those pertaining to verification, renewal, late renewal, inactivation, reactivation and continuing education requirements.

This rule is intended to implement Iowa Code section 147.2.

[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.7(17A,147,152,272C) License cycle.**

**3.7(1) Name and address changes.** Written notification to the board of name and address changes is required within 30 days of the event. Licensure documents are mailed to the licensee at the address on file in the board office. There is no fee for a change of name or address in board records.

**3.7(2) New licenses.** The board shall issue licenses by endorsement and examination for a 24- to 36-month period. When the license is renewed, it will be placed on a three-year renewal cycle. Expiration shall be on the fifteenth day of the birth month.

**3.7(3) Renewal.** The licensee may renew the license beginning 60 days prior to license expiration. Renewal is available online at the board's Web site or by mail upon request. When the licensee has satisfactorily completed the requirements for renewal, a wallet card shall be mailed to the licensee.

*a.* The licensee shall:

(1) Attest that Iowa is the primary state of residence as outlined in rule 655—16.2(152E) or that the primary state of residence is a noncompact state. The board may request evidence of residency.

(2) Submit the renewal application and the renewal fee as specified in rule 655—3.1(17A,147,152, 272C).

(3) Meet the continuing education requirement as set forth in 655—Chapter 5, prior to license renewal.

(4) Complete the required mandatory reporter training set forth in paragraph 3.7(3)“b.”

*b.* Mandatory reporter training.

(1) The course shall be a curriculum approved by the Iowa department of public health.

(2) A licensee who regularly examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of two hours of training in child abuse identification and reporting in the previous five years or condition(s) for rule suspension as identified in subparagraph 3.7(3)“b”(6).

(3) A licensee who regularly examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of two hours of training in dependent adult abuse identification and reporting in the previous five years or condition(s) for rule suspension as identified in subparagraph 3.7(3)“b”(6).

(4) A licensee who regularly examines, attends, counsels or treats both adults and children in Iowa shall indicate on the renewal application completion of training on abuse identification and reporting in dependent adults and children or condition(s) for rule suspension as identified in subparagraph 3.7(3)“b”(6). Training may be completed through separate courses as identified in subparagraphs 3.7(3)“b”(2) and (3) or in one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse.

(5) The licensee shall maintain written documentation for five years after mandatory training as identified in subparagraphs 3.7(3)“b”(2) to (4), including program date(s), content, duration, and proof of participation.

(6) The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

1. Is engaged in active duty in the military service of this state or the United States.

2. Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements, including waiver of continuing education requirements or extension of time in which to fulfill requirements due to a physical or mental disability or illness as identified in 655—Chapter 5.

(7) The board may select licensees for audit of compliance with the requirements in subparagraphs 3.7(3)“b”(1) to (6).

**3.7(4) Late renewal.** The license shall become late when the license has not been renewed by the expiration date on the wallet card. The licensee shall be assessed a late fee as specified in rule 655—3.1(17A,147,152,272C).

To renew a late license, the licensee shall complete the renewal requirements and submit the late fee before the fifteenth day of the month following the expiration date on the wallet card.

**3.7(5) Inactive status.** The license shall become inactive when the license has not been renewed by the fifteenth day of the month following the expiration date on the wallet card or the board office has been notified by another compact state that a licensee has declared a new primary state. Pursuant to 655—subrule 16.2(8), the former home state license shall no longer be valid upon the issuance of a new home state license.

a. If the inactive license is not reactivated, it shall remain inactive.

b. If the licensee resides in Iowa or a noncompact state, the licensee shall not practice nursing in Iowa until the license is reactivated to active status. If the licensee is identified as practicing nursing with an inactive license, disciplinary proceedings shall be initiated.

c. The licensee is not required to obtain continuing education credit or pay fees while the license is inactive.

d. To reactivate the license, the licensee shall complete the reactivation requirements.

(1) The licensee shall be provided an application, a continuing education report form, two fingerprint cards, a waiver form, and statement of the fees. The reactivation fee and criminal history background check fee are specified in the definition of “fees” in rule 655—3.1(17A,147,152,272C).

(2) The licensee shall have obtained 12 contact hours of continuing education, as specified in 655—Chapter 5, within the 12 months prior to reactivation.

(3) Upon receipt of the completed reactivation application, required continuing education materials, two completed fingerprint cards and a signed waiver form to facilitate a national criminal history background check, fees for both the reactivation and the criminal history background check and verification that the primary state of residence is Iowa or a noncompact state, the licensee shall be issued a license for a 24- to 36-month period. At the time of the next renewal, the license will be placed on a three-year renewal cycle. Expiration shall be on the fifteenth day of the licensee’s birth month. The board staff may issue a certificate of license prior to receipt of a report on the applicant from the DCI/FBI.

(4) An applicant who fails to complete the reactivation of licensure process within 12 months from the date of application must reapply. All fees are nonrefundable.

**3.7(6) Duplicate wallet card or certificate.** A duplicate wallet card or certificate shall be required if the current card or certificate is lost, stolen, destroyed or not received by the licensee within 60 days from the date the license is issued. The licensee shall be issued a duplicate wallet card or certificate upon receipt of an application for a duplicate wallet card or certificate and receipt of the fee as specified in rule 655—3.1(17A,147,152,272C). If the licensee notifies the board that the wallet card or certificate has not been received within 60 days after being issued, no fee shall be required. A fee is applicable when the licensee fails to notify the board of a name or address change.

**3.7(7) Reissue of a certificate or wallet card.** The board shall reissue a certificate or current wallet card upon receipt of a written request from the licensee, return of the original document and payment of the fee as specified in rule 655—3.1(17A,147,152,272C). No fee shall be required if an error was made by the board on the original document.

This rule is intended to implement Iowa Code sections 147.2 and 147.9 to 147.11.  
[ARC 8222B, IAB 10/7/09, effective 11/11/09; ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.8(17A,147,152,272C) Verification.** Upon written request from the licensee or another jurisdiction and payment of the verification fee as specified in rule 655—3.1(17A,147,152,272C), the board shall provide a certified statement to another jurisdiction or entity that the license of a registered nurse, licensed practical nurse or advanced registered nurse practitioner is active, inactive or encumbered/disciplined in Iowa.

This rule is intended to implement Iowa Code sections 147.2 and 147.8.  
[ARC 1815C, IAB 1/7/15, effective 2/11/15]

**655—3.9(17A,272C) License denial.**

**3.9(1)** Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that cites the factual and legal basis for denying the application, notifies the applicant of the appeal process and specifies the date upon which the denial will become final if not appealed.

**3.9(2)** An applicant who has been issued a preliminary notice of denial may appeal the notice and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director within 30 days following the date the preliminary notice of denial was mailed. The request for hearing shall specify the factual or legal errors in the preliminary notice of denial and provide any additional written information or documents in support of the licensure.

**3.9(3)** All hearings held pursuant to this rule shall be held in accordance with the process outlined in 655—Chapter 4.

**3.9(4)** If an applicant does not appeal a preliminary notice of denial, the preliminary notice of denial automatically becomes final and a notice of denial will be issued.

This rule is intended to implement Iowa Code chapters 17A and 272C.  
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## **REVENUE DEPARTMENT[701]**

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ADMINISTRATION  
[Prior to 1/1/96, see 701—Ch 63]

**701—67.1(452A) Definitions.** For purposes of this chapter, 701—Chapter 68, and 701—Chapter 69, the following definitions shall govern:

“*Appropriate state agency*” or “*state agency*” means the department of revenue or the state department of transportation, whichever is responsible for control, maintenance, or supervision of the power, requirement, or duty referred to in Iowa Code chapter 452A.

“*Aviation gasoline*” means any gasoline capable of being used for propelling aircraft which is invoiced as aviation gasoline or is received, sold, stored, or withdrawn from storage for purposes of propelling aircraft. It does not include motor fuel capable of being used for propelling motor vehicles.

“*Biodiesel*” means a renewable fuel comprised of mono-alkyl esters of long-chain fatty acids derived from vegetable oils or animal fats, which meets the standards provided in Iowa Code section 214A.2.

“*Biodiesel blended fuel*” means a blend of biodiesel with petroleum-based diesel fuel which meets the standards, including separately the standard for its biodiesel component, provided in Iowa Code section 214A.2.

“*Biofuel*” means ethanol or biodiesel.

“*Blender*” means a person who owns and blends ethanol with gasoline to produce ethanol blended gasoline and blends the product at a nonterminal location. The person is not restricted to blending ethanol with gasoline. Products blended with gasoline other than ethanol are taxed as gasoline. “*Blender*” also means a person blending two or more special fuel products at a nonterminal location where the tax has not been paid on all of the products blended. The blend is taxed as a special fuel.

“*Carrier*” means and includes any person who operates or causes to be operated any commercial motor vehicle on any public highway in this state.

“*Common carrier*” or “*contract carrier*” means a person involved in the movement of motor fuel or special fuel from the terminal or movement of the motor fuel or special fuel imported into this state, who is not an owner of the motor fuel or special fuel.

“*Commercial motor vehicle*” means a passenger vehicle that has seats for more than nine passengers in addition to the driver, any road tractor, any truck tractor, or any truck having two or more axles which passenger vehicle, road tractor, truck tractor, or truck is propelled on the public highways by either motor fuel or special fuel. “*Commercial motor vehicle*” does not include a motor truck with a combined gross weight of less than 26,000 pounds, operated as a part of an identifiable one-way fleet and which is leased for less than 30 days to a lessee for the purpose of moving property which is not owned by the lessor.

“*Conventional blendstock for oxygenate blending*” means one or more motor fuel components intended for blending with an oxygenate or oxygenates to produce gasoline.

“*Dealer*” means a person, other than a distributor, who engages in the business of selling or distributing motor fuel or special fuel to the end user in this state.

“*Denatured ethanol*” means ethanol that is to be blended with gasoline, has been derived from cereal grains, complies with American Society of Testing Materials designation D-4806-95b, and may be denatured only as specified in Code of Federal Regulations, Titles 20, 21, and 27. Alcohol and denatured ethanol have the same meaning.

“*Department*” means the department of revenue.

“*Diesel fuel*” or “*diesel*” means diesel as defined in Iowa Code section 214A.1.

“*Director*” means the director of the Iowa department of revenue or the director’s authorized representative.

“*Distributor*” means a person who acquires tax-paid motor fuel, special fuel, or alcohol from a supplier, restrictive supplier, or importer, or another distributor for subsequent sale at wholesale and distribution by tank cars or tank trucks or both. The department may require that the distributor be registered to have terminal purchase rights.

*"E-85 gasoline"* means ethanol blended gasoline formulated with a minimum percentage of between 70 and 85 percent by volume of ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2.

*"Eligible purchaser"* means a distributor of motor fuel or special fuel who elects to make delayed payments to a licensed supplier and must use electronic funds transfer.

*"End user"* of special fuel means a person who has purchased a minimum of 240,000 gallons of special fuel each year in the two preceding years who elects to make delayed payments to a licensed supplier and must use electronic funds transfer.

*"Ethanol"* means ethyl alcohol that is to be blended with gasoline if the ethanol meets the standards provided in Iowa Code section 214A.2.

*"Ethanol blended gasoline"* means a formulation of gasoline which is a liquid petroleum product blended with ethanol, if the formulation meets the standards provided in Iowa Code section 214A.2. When "motor fuel" is used in these rules, it includes ethanol blended gasoline.

*"Ethanol distribution percentage"* means the number of gallons of ethanol blended gasoline that is distributed in this state as expressed as a percentage of the number of gallons of motor fuel, excluding aviation gasoline, distributed in this state during the determination period. The determination period is the previous calendar year.

*"Export"* means delivery across the boundaries of this state by or for the seller or purchaser from a place of origin in this state.

*"Exporter"* means a person or other entity who acquires fuel in this state for export to another state.

*"Foreign supplier"* means a person licensed as a supplier to collect and report the tax, but who does not have jurisdictional connections with this state.

*"Fuel(s)"* means and includes both motor fuel and special fuel as defined in Iowa Code chapter 452A.

*"Fuel taxes"* means the per gallon excise taxes imposed under division I of Iowa Code chapter 452A with respect to motor fuel and undyed special fuel.

*"Gallon,"* with respect to compressed natural gas, means a gasoline gallon equivalent. A gasoline gallon equivalent of compressed natural gas is five and sixty-six hundredths pounds or one hundred twenty-six and sixty-seven hundredths cubic feet measured at a base temperature of 60 degrees Fahrenheit and a pressure of fourteen and seventy-three hundredths pounds per square inch absolute. "Gallon," with respect to liquefied natural gas, means a diesel gallon equivalent. A diesel gallon equivalent of liquefied natural gas is six and six hundredths pounds.

*"Gasoline"* means any liquid product prepared, advertised, offered for sale or sold for use as, or commonly and commercially used as, motor fuel for use in a spark-ignition, internal combustion engine, and which meets the specifications provided in Iowa Code section 214A.2.

*"Import"* means delivery across the boundaries of this state by or for the seller or purchaser from a place of origin outside this state.

*"Importer"* means a person who imports motor fuel or undyed special fuel in bulk or transport load into the state by truck, rail, or barge.

*"Invoiced gallons"* means gross gallons as shown on the bill of lading or manifest.

*"Iowa urban transit system"* means a system whereby motor buses are operated primarily upon the streets of cities for the transportation of passengers for an established fare and which accepts passengers who present themselves for transportation without discrimination up to the limit of the capacity of each motor bus. "Iowa urban transit system" also includes motor buses operated upon the streets of adjoining cities, whether interstate or intrastate, for the transportation of passengers without discrimination up to the limit of the capacity of the motor bus.

Privately chartered bus services, motor carriers and interurban carriers subject to the jurisdiction of the state department of transportation, school bus services, and taxicabs shall not be construed to be an urban transit system nor a part of any such system.

*"Licensee"* means a person holding an uncanceled supplier's, restrictive supplier's, importer's, exporter's, or blender's license issued by the department or any other person who possesses fuel for which the tax has not been paid.

*“Mobile machinery and equipment”* means vehicles self-propelled by an internal combustion engine but not designed or used primarily for the transportation of persons or property on public highways and only incidentally operated or moved over a highway including, but not limited to, corn shellers, truck-mounted feed grinders, roller mills, ditch-digging apparatus, power shovels, draglines, earth-moving equipment and machinery, and road construction and maintenance machinery such as asphalt spreaders, bituminous mixers, bucket loaders, ditchers, leveling graders, finishing machines, motor graders, paving mixers, road rollers, scarifiers, and earth-moving scrapers. However, “mobile machinery and equipment” does not include dump trucks or self-propelled vehicles originally designed for the transportation of persons or property on public highways and to which machinery, such as truck-mounted transit mixers, cranes, shovels, welders, air compressors, well-boring apparatus or lime spreaders, has been attached.

*“Motor fuel”* means a substance or combination of substances which is intended to be or is capable of being used for the purpose of operating an internal combustion engine, including but not limited to a motor vehicle, and is kept for sale or sold for that purpose and includes the following:

1. All products commonly or commercially known or sold as gasoline (including ethanol blended gasoline, casinghead, and absorption or natural gasoline) regardless of their classifications or uses, and including transmix which serves as a buffer between fuel products in the pipeline distribution process.

2. Any liquid advertised, offered for sale, sold for use as, or commonly or commercially used as a fuel for propelling motor vehicles, which when subjected to distillation of gasoline, naphtha, kerosene, and similar petroleum products (American Society of Testing Materials designation D-86), shows not less than 10 percent distilled (recovered) below 347° F (175° C) and not less than 95 percent distilled (recovered) below 464° F (240° C).

*“Motor fuel”* does not include special fuel and does not include liquefied gases which would not exist as liquids at a temperature of 60° F and a pressure of 14 7/10 pounds per square inch absolute, or naphthas and solvents unless the liquefied gases or naphthas and solvents are used as a component in the manufacture, compounding, or blending of a liquid within paragraph “2,” in which event the resulting product shall be deemed to be motor fuel. “Motor fuel” also does not include methanol unless blended with other motor fuels for use in an aircraft or for propelling motor vehicles.

*“Motor vehicle”* means and includes all vehicles (except those operated on rails) which are propelled by internal combustion engines and are of such design as to permit their mobile use on public highways for transporting persons or property. A farm tractor while operated on a farm or for the purpose of hauling farm machinery, equipment, or produce shall not be deemed to be a motor vehicle. “Motor vehicle” shall not include “mobile machinery and equipment.”

*“Naphthas and solvents”* means and includes those liquids which come within the distillation specifications for motor fuel, but which are designed and sold for exclusive use other than as a fuel for propelling motor vehicles.

*“Non-ethanol blended gasoline”* means gasoline other than ethanol blended gasoline.

*“Nonrefiner biofuel manufacturer”* means an entity that produces, manufactures, or refines biofuel and does not directly or through a related entity refine, blend, import, or produce a conventional blendstock for oxygenate blending, gasoline, or diesel fuel.

*“Nonterminal storage facility”* means a facility where motor fuel or special fuel, other than liquefied petroleum gas, is stored that is not supplied by a pipeline or a marine vessel. “Nonterminal storage facility” includes a facility that manufactures products such as ethanol, biofuel, blend stocks, or additives which may be used as motor fuel or special fuel, other than liquefied petroleum gas, for operating motor vehicles or aircraft.

*“Person”* means and includes natural persons, partnerships, firms, associations, corporations, representatives appointed by any court, and political subdivisions of this state or any other group or combination acting as a unit and the plural as well as the singular number applies.

*“Public highways”* means and includes any way or place available to the public for purposes of vehicular travel notwithstanding temporarily closed.

“*Racing fuel*” means leaded gasoline of 110 octane or more that does not meet American Society of Testing Materials designation D-4814 for gasoline and is sold in bulk for use in nonregistered motor vehicles.

“*Refiner*” means a person engaged in the refining of crude oil to produce motor fuel or special fuel, and includes any affiliate of such person.

“*Regional transit system*” means a public transit system serving one county or all or part of a multicounty area whose boundaries correspond to the same boundaries as those of the regional planning areas designated by the governor, except as agreed upon by the department. Each county board of supervisors within the region is responsible for determining the service and funding within its county. However, the administration and overhead support services for the overall regional transit system shall be consolidated into one existing or new agency to be mutually agreed upon by the participating members. Privately chartered bus services and uses other than providing services that are open and public on a shared-ride basis shall not be construed to be a regional transit system.

“*Restrictive supplier*” means a person not otherwise licensed as an importer who imports motor fuel or undyed special fuel into this state in amounts of less than 4,000 gallons in tank wagons or in small tanks.

“*Special fuel*” means fuel oils, kerosene and all combustible gases and liquids suitable for the generation of power for propulsion of motor vehicles or turbine-powered aircraft, and includes any substance used for that purpose, except that it does not include motor fuel. Kerosene and methanol shall not be considered to be special fuels, unless the kerosene or methanol is blended with other special fuels for use in a motor vehicle with a diesel engine.

“*Supplier*” means a person who acquires motor fuel or special fuel by pipeline or marine vessel from a state, territory, or possession of the United States, or from a foreign country for storage at and distribution from a terminal and who is registered under 26 U.S.C. § 4101 for tax-free transactions in gasoline; a person who produces in this state or acquires by truck, railcar, or barge for storage at and distribution from a terminal, biofuel, biodiesel, alcohol, or alcohol derivative substances; or a person who produces, manufactures, or refines motor fuel or special fuel in this state. “Supplier” includes a person who does not meet the jurisdictional connection to this state but voluntarily agrees to act as a supplier for purposes of collecting and reporting the motor fuel or special fuel tax. “Supplier” does not include a retail dealer or wholesaler who merely blends alcohol with gasoline or biofuel with diesel before the sale or distribution of the product or a terminal operator who merely handles, in a terminal, motor fuel or special fuel consigned to the terminal operator.

“*Taxpayer*” means anyone responsible for paying fuel taxes directly to the department of revenue under Iowa Code chapter 452A.

“*Terminal*” means a motor fuel, alcohol, or special fuel storage and distribution facility that is supplied by a pipeline or a marine vessel and from which the fuel may be removed at a rack. “Terminal” does not include a facility at which motor fuel or special fuel blend stocks and additives are used in the manufacture of products other than motor fuel or special fuel and from which no motor fuel or special fuel is removed.

“*Terminal operator*” means the person who by ownership or contractual agreement is charged with the responsibility for, or physical control over, and operation of a terminal. If coventurers own a terminal, “terminal operator” means the person who is appointed to exercise the responsibility for, or physical control over, and operation of the terminal.

“*Terminal owner*” means a person who holds a legal or equitable interest in a terminal.

“*Withdrawn from terminal*” means physical movement from a supplier to a distributor or eligible end user or from an alcohol manufacturer to a nonterminal location and includes an importer going out of state and obtaining fuel from a terminal and bringing the fuel into the state, and a restrictive supplier bringing fuel into the state even though not purchased directly from a terminal. Exchange of product by suppliers while in the distribution channel and the physical movement of alcohol from an alcohol manufacturer

to an Iowa licensed supplier's alcohol storage at a terminal are not to be considered "withdrawn from terminal."

This rule is intended to implement Iowa Code sections 452A.2 and 452A.59.  
[ARC 1442C, IAB 4/30/14, effective 6/4/14; ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—67.2(452A) Statute of limitations, supplemental assessments and refund adjustments.** After a return is filed, the department must examine it, determine fuel taxes due, and give notice of assessment to the taxpayer. If no return is filed, the department may determine the tax due and give notice thereof. See rule 701—67.5(452A). The period for the examination and determination of the correct amount of tax is unlimited in the case of a false or fraudulent return made with the intent to evade tax or in the case of a failure to file a return.

The department may, at any time within the period prescribed for assessment or refund adjustment, make a supplemental assessment or refund adjustment whenever it is ascertained that any assessment or refund adjustment is imperfect or incomplete in any respect.

If the assessment or refund adjustment is appealed (protested under rule 701—7.8(17A)) and is resolved whether by informal proceedings or by adjudication, the department and the taxpayer are precluded from making a supplemental assessment or refund adjustment concerning the same issue involved in such appeal for the same tax period unless there is a showing of mathematical or clerical error or a showing of fraud or misrepresentation.

The three-year period of limitation may be extended by a taxpayer by signing a waiver agreement form to be provided by the department. The agreement must stipulate the period of extension and must also provide that a claim for refund may be filed by the taxpayer at any time during the period of extension.

This rule is intended to implement Iowa Code section 452A.67 as amended by 1999 Iowa Acts, Senate File 136.  
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

**701—67.3(452A) Taxpayers required to keep records.** The records required to be kept by this rule must be preserved for a period of three years and will be open for examination by the department during this period of time. The department, after an audit and examination of the records, may authorize the disposal of the records required to be kept upon written request by the taxpayer. For taxpayers using an electronic data interchange process or technology also see 701—subrule 11.4(4).

**67.3(1) Motor fuel and special fuel supplier.** Every supplier required to file a monthly return under Iowa Code section 452A.8 is required to keep and preserve the following records relating to the purchase or sale of fuel:

- a. Copies of bills of lading or manifests.
- b. Copies of sales invoices.
- c. Sales records.
- d. Copies of filed returns and supporting schedules.
- e. Record of payment.
- f. Export schedules.

**67.3(2) Restrictive supplier.** Every restrictive supplier required to file a monthly return under Iowa Code section 452A.8 is required to keep and preserve the following records relating to the purchase or sale of fuel:

- a. Copies of bills of lading or manifests.
- b. Purchase invoices.
- c. Copies of sales invoices.
- d. Purchase records.
- e. Sales records.
- f. Copies of filed returns and supporting schedules.
- g. Record of payment.

**67.3(3) Importer.** Every importer required to file a semimonthly return under Iowa Code section 452A.8 is required to keep and preserve the following records relating to the purchase or sale of fuel:

- a. Copies of bills of lading or manifests.
- b. Purchase invoices.
- c. Copies of sales invoices.
- d. Purchase records.
- e. Sales records.
- f. Copies of filed returns and supporting schedules.
- g. Record of payment.

**67.3(4) Exporter.** Every exporter is required to keep and preserve the following records relating to the purchase of fuel for export:

- a. Copies of bills of lading or manifests.
- b. Purchase invoices and purchase records.
- c. Copies of reports, returns, and supporting schedules filed with the importing state.
- d. Record of payment.

**67.3(5) Compressed natural gas, liquefied natural gas, and liquefied petroleum gas dealers and users.** Every compressed natural gas, liquefied natural gas, and liquefied petroleum gas dealer and user is required to keep and preserve the following records:

- a. Copies of purchase invoice or bills of lading.
- b. Copies of sales invoices and sales records.
- c. Record of payment.
- d. Exemption certificates.
- e. Copies of filed returns and supporting schedules.

**67.3(6) Terminal or nonterminal storage facility operator.** Every person required to report under Iowa Code section 452A.15(2) or 2002 Iowa Acts, House File 2622, section 25, as an operator of a terminal or nonterminal storage facility shall keep and preserve the following records:

- a. Records to evidence the acquisition of fuel.
- b. Bills of lading or manifests covering the withdrawal of fuel.
- c. Copies of filed reports and supporting schedules.

**67.3(7) Distributor.** Every distributor handling motor fuel or special fuel is required to preserve and keep the following records:

- a. Delivery tickets.
- b. Sales invoices.
- c. Bills of lading.
- d. Record of payment.

**67.3(8) Blender.** Every blender is required to keep and preserve the following records:

- a. Purchase invoices for motor fuel, special fuel, and alcohol.
- b. Bills of lading.
- c. Copies of filed returns and supporting schedules.
- d. Record of payment.
- e. Copies of sales invoices.

**67.3(9) Dealer.** Every dealer (retailer) is required to keep and preserve the following records:

- a. Purchase invoices.
- b. Purchase records.
- c. Delivery tickets.
- d. Sales invoices.
- e. Sales records.
- f. Record of payment.

**67.3(10) Microfilm and related record systems.** Microfilm, microfiche, COM (computer on machine), and other related reduction in storage systems will be referred to as "microfilm" in this rule.

Microfilm reproductions of general books of account, such as a cash book, journals, voucher registers, and ledgers, are not acceptable other than those that have been approved by the Internal Revenue Service under Revenue Procedure 76-43, Section 3.02. However, microfilm reproductions of supporting records of detail, such as sales invoices and purchase invoices, may be allowed providing

there is no administrative rule or Iowa Code section requiring the original and all of the following conditions are met and accepted by the taxpayer:

- a. Appropriate facilities are provided to ensure the preservation and readability of the films.
- b. Microfilm rolls are indexed, cross-referenced, labeled to show beginning and ending numbers or beginning and ending alphabetical listing of documents included, and are systematically filed.
- c. The taxpayer agrees to provide transcripts of any information contained on microfilm which may be required for purposes of verification of tax liability.
- d. Proper facilities are provided for the ready inspection and location of the particular records, including modern projectors for viewing and for the copying of records.
- e. Any audit of “detail” on microfilm may be subject to sample audit procedures, to be determined at the discretion of the director or the director’s designated representative.
- f. A posting reference must be on each invoice.
- g. Documents necessary to support claimed exemptions from tax liability, such as bills of lading and purchase orders, must be maintained in an order by which they readily can be related to the transaction for which exemption is sought.

**67.3(11) Automatic data processing records.** Automatic data processing (ADP) is defined in this rule as including electronic data processing (EDP) and will be referred to as ADP.

a. An ADP tax accounting system must have built into its program a method of producing visible and legible records which will provide the necessary information for verification of the taxpayer’s tax liability.

b. ADP records must provide an opportunity to trace any transaction back to the original source or to a final total. If detailed printouts are not made of transactions at the time they are processed, then the system must have the ability to reconstruct these transactions.

c. A general ledger with source references will be produced as hard copy to coincide with financial reports of tax reporting periods. In cases where subsidiary ledgers are used to support the general ledger accounts, the subsidiary ledgers should also be produced periodically.

d. Supporting documents and audit trail. The audit trail should be designed so that the details underlying the summary accounting data may be identified and made available to the director or the director’s designated representative upon request. The system should be designed so that the supporting documents, such as sales invoices and purchase invoices, are readily available. (An audit trail is defined as the condition of having sufficient documentary evidence to trace an item from source, such as invoice or payment, to a financial statement or tax return or report; or the reverse, that is, to have an auditable system.)

e. Program documentation. A description of the ADP portion of the accounting program should be available. The statements and illustrations as to the scope of operations should be sufficiently detailed to indicate:

- (1) The application being performed;
- (2) The procedure employed in each application (which, for example, might be supported by flow charts, block diagrams or other satisfactory description of the input or output procedures); and
- (3) The controls used to ensure accurate and reliable processing. Program and systems changes, together with their effective dates, should be noted in order to preserve an accurate chronological record.

f. Storage of ADP output will be in appropriate facilities to ensure preservation and readability of output.

**67.3(12) Electronic data interchange or EDI technology.** The purpose of this subrule is to adopt the “Model Recordkeeping and Retention Regulation” report as promulgated by the Federation of Tax Administrators’ Steering Committee Task Force on EDI Audit and Legal Issues for Tax Administration (March 1996). This subrule defines the requirements imposed on taxpayers for the maintenance and retention of books, records, and other sources of information under Iowa Code sections 452A.10, 452A.12, 452A.55, 452A.60, 452A.62, 452A.69, 452A.76, and 452A.80. It is also the purpose of this subrule to address these requirements where all or part of a taxpayer’s records are received, created, maintained, or generated through various computer, electronic, and imaging processes and systems. A taxpayer must maintain all records that are necessary for determination of the correct tax liability as set

forth in this subrule and the other subrules within rule 701—67.3(452A). Upon request, all required records must be made available to the department or its authorized representatives as provided in Iowa Code sections 452A.10 and 452A.62. If a taxpayer retains records required to be retained under this subrule in both machine-sensible and hard-copy formats, the taxpayer must make the records available to the department in machine-sensible format upon request of the department. Nothing in this subrule will be construed to prohibit a taxpayer from demonstrating tax compliance with traditional hard-copy documents or reproductions thereof, in whole or in part, whether or not the taxpayer also has retained or has the capability to retain records on electronic or other storage media in accordance with this subrule. However, as previously stated, this will not relieve a taxpayer of the obligation to comply with the requirement to make records available to the department.

*a. Definitions.* The following definitions are applicable to this subrule:

“*Database management system*” means a software system that controls, relates, retrieves, and provides accessibility to data stored in a database.

“*Electronic data interchange*” or “*EDI technology*” means the computer-to-computer exchange of business transactions in a standardized, structured electronic format.

“*Hard copy*” means any documents, records, reports, or other data printed on paper.

“*Machine-sensible record*” means a collection of related information in an electronic format. Machine-sensible records do not include hard-copy records that are created or recorded on paper or stored in or by an imaging system such as microfilm, microfiche, or storage-only imaging systems.

“*Storage-only imaging system*” means a system of computer hardware and software that provides for the storage, retention, and retrieval of documents originally created on paper. It does not include any system, or part of a system, that manipulates or processes any information or data contained on the document in any manner other than to reproduce the document in hard copy or as an optical image.

“*Taxpayer*” as used in this subrule means any person, business, corporation, fiduciary, or other entity that is required to file a return or report with the department of revenue.

*b. Record-keeping requirements — machine-sensible records.* A taxpayer that maintains and retains books, records, and other sources of information in the form of machine-sensible records must comply with the following:

(1) General requirements. A taxpayer must comply with the following general requirements regarding the retention of machine-sensible records:

1. Machine-sensible records used to establish tax compliance must contain sufficient transaction-level detail information so that the details underlying the machine-sensible records can be identified and made available to the department upon request. A taxpayer has discretion to discard duplicated records and redundant information provided its responsibilities under this regulation are met.

2. At the time of an examination, the retained records must be capable of being retrieved and converted to a standard record format. The term “standard record format” does not mean that every taxpayer must keep records in an identical manner. Instead, it requires that if a taxpayer utilizes a code system to identify elements of information in each record when creating and maintaining records, the taxpayer is required to maintain a record of the meaning of each code and any code changes so that the department may effectively review the taxpayer’s records.

3. Taxpayers are not required to construct machine-sensible records other than those created in the ordinary course of business. A taxpayer that does not create the electronic equivalent of a traditional paper document in the ordinary course of business is not required to construct a traditional paper document for tax purposes.

(2) Electronic data interchange requirements. A taxpayer must comply with the following requirements for records received through electronic data interchange:

1. Where a taxpayer uses an electronic data interchange process and technology, the level of record detail, in combination with other records related to the transactions, must be equivalent to that contained in an acceptable paper record. For example, for motor fuel tax purposes the retained records should contain the following minimal information: bills of lading or manifests; invoices; sales and purchase records; returns, reports, and supporting schedules; records of payments; export schedules; exemption

certificates; and delivery tickets. Codes may be used to identify some or all of the data elements, provided that the taxpayer provides a method which allows the department to interpret the coded information.

2. The taxpayer may capture the information necessary to satisfy the requirements set forth in the preceding paragraph at any level within the accounting system and need not retain the original EDI transaction records provided that the audit trail, authenticity, and integrity of the retained records can be established. For example, a taxpayer using electronic data interchange technology receives electronic invoices from its suppliers. The taxpayer decides to retain the invoice data from completed and verified EDI transactions in its accounts payable system rather than to retain the EDI transactions themselves. Since neither the EDI transaction nor the accounts payable system captures information from the invoice pertaining to product description and vendor name (i.e., they contain only codes for that information), the taxpayer also retains the other records such as its vendor master file and product code description lists and makes them available to the department. In this example, the taxpayer need not retain its original EDI transaction for tax purposes.

(3) Electronic data processing accounting systems requirements. The requirements for an electronic data processing accounting system should be similar to that of a manual accounting system, in that an adequately designed accounting system should incorporate methods and records that will satisfy the requirements of this rule. In addition, pursuant to Iowa Code sections 452A.10, 452A.12, 452A.55, 452A.60, 452A.62, 452A.69, 452A.76, and 452A.80, the department must have access to the taxpayer's EDI processing, accounting, or other systems for the purposes of verifying or evaluating the integrity and reliability of those systems to provide accurate and complete records.

(4) Business process information. To verify the accuracy of the records being retained, the taxpayer must comply with the following:

1. Upon the request of the department, the taxpayer shall provide a description of the business process that created the retained records. The description must include the relationship between the records and the tax documents prepared by the taxpayer and include the measures employed to ensure the integrity of the records.

2. The taxpayer must be capable of demonstrating the following:

- The functions being performed as they relate to the flow of data through the system;
- The internal controls used to ensure accurate and reliable processing; and
- The internal controls used to prevent unauthorized addition to, alteration of, or deletion of retained records.

3. The following specific documentation is required for machine-sensible records retained pursuant to this rule:

- Record formats or layouts;
- Field definitions (including a record of any changes in the system or codes and the meaning of all codes used to represent information);
- File descriptions (e.g., data set name); and
- Detailed charts of accounts and account descriptions.

*c. Record maintenance requirements.* The department recommends, but does not require, that taxpayers refer to the National Archives and Record Administration's (NARA) standards for guidance on the maintenance and storage of electronic records such as the labeling of records, the location and security of the storage environment, the creation of backup copies, and the use of periodic testing to confirm the continued integrity of the records. (The NARA standards may be found at 36 Code of Federal Regulations, Part 1234, July 1, 1995, Edition.) The taxpayer's computer hardware and software must accommodate the extraction and conversion of retained machine-sensible records.

*d. Access to machine-sensible records.* If a taxpayer retains records required to be retained under this regulation in both machine-sensible and hard-copy formats, the taxpayer must make the records available to the department in machine-sensible format upon the request of the department.

(1) The manner in which the department is provided access to machine-sensible records may be satisfied through a variety of means that must take into account a taxpayer's facts and circumstances through consultation with the taxpayer.

(2) Access shall be provided in one or more of the following manners:

1. The taxpayer may arrange to provide the department with the hardware, software, and personnel resources to access the machine-sensible records.

2. The taxpayer may arrange for a third party to provide the hardware, software, and personnel resources necessary to access the machine-sensible records.

3. The taxpayer may convert the machine-sensible records to a standard record format specified by the department, including copies of files, on magnetic medium that is agreed to by the department.

4. The taxpayer and the department may agree on other means of providing access to the machine-sensible records.

*e. Taxpayer's responsibility and discretionary authority.* In conjunction with meeting the requirements of paragraph "b" of this subrule, a taxpayer may create files solely for the use of the department. For example, if a database management system is used, it is consistent with this subrule for the taxpayer to create and retain a file that contains the transaction-level detail from the database management system and that meets the requirements of paragraph "b" of this subrule. The taxpayer shall document the process that created the separate file to show the relationship between that file and the original records. A taxpayer may contract with a third party to provide custodial or management services of the records. Such a contract will not relieve the taxpayer of its responsibilities under this rule.

*f. Alternative storage media.* For purposes of storage and retention, taxpayers may convert hard-copy documents received or produced in the normal course of business and required to be retained under this rule to microfilm, microfiche, or other storage-only imaging systems and may discard the original hard-copy documents provided that the rules governing alternative storage media are met. For details regarding alternative storage, see subrule 67.3(9), "Microfilm and related record systems."

*g. Effect on hard-copy record-keeping requirements.* Except as otherwise provided, the provisions of this subrule do not relieve taxpayers of the responsibility to retain hard-copy records that are created or received in the ordinary course of business as required by existing law and rules. Hard-copy records may be retained on alternative storage media as indicated in paragraph "f" above and subrule 67.3(9).

If hard-copy records are not produced or received in the ordinary course of transacting business (e.g., when the taxpayer uses electronic data interchange technology), hard-copy records need not be created.

Hard-copy records generated at the time of the transaction with the use of a credit or debit card must be retained unless all the details necessary to determine correct tax liability relating to the transaction are subsequently received and retained by the taxpayer in accordance with this rule.

Computer printouts that are created for validation, control, or other temporary purposes need not be retained.

Nothing in this rule shall prevent the department from requesting hard-copy printouts in lieu of retained machine-sensible records at the time of examination.

**67.3(13) General requirements.** If a tax liability has been assessed and an appeal is pending to the department, state board of tax review, or district or supreme court, books, papers, records, memoranda, or documents specified in this rule which relate to the period covered by the assessment must be preserved until the final disposition of the appeal.

If the requirements of this rule are not met, the records will be considered inadequate and rule 701—67.5(452A), estimate gallonage, applies.

This rule is intended to implement Iowa Code sections 452A.6 and 452A.15 as amended by 2002 Iowa Acts, House File 2622, and sections 452A.8, 452A.9, 452A.10, 452A.17, 452A.59, 452A.60, 452A.62, and 452A.69.

[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—67.4(452A) Audit—costs.** The department has the right and duty to examine or cause to be examined the books, records, memoranda, or documents of a taxpayer for the purpose of verifying the correctness of a return filed or determining the tax liability of any taxpayer. The costs incurred in examining the records of a taxpayer are at the taxpayer's expense when the records are kept at an

out-of-state location. Cost will include meals, lodging, and travel expenses, but will not include salaries of department personnel. (See 1976 O.A.G. 611.)

This rule is intended to implement Iowa Code section 452A.10 and 452A.62 as amended by 1995 Iowa Acts, chapter 155, and Iowa Code sections 452A.55 and 452A.69.

**701—67.5(452A) Estimate gallonage.** It is the duty of the department to collect all taxes on fuel due the state of Iowa. In the event the taxpayer's records are lacking or inadequate to support any return filed by the taxpayer, or to determine the taxpayer's liability, the department has the power to estimate the gallonage upon which tax is due. This estimation will be based upon such factors as, but not limited to, the following: (1) prior experience of the taxpayer, (2) taxpayers in similar situations, (3) industry averages, (4) records of suppliers or customers, and (5) other pertinent information the department may possess, obtain or examine.

This rule is intended to implement Iowa Code section 452A.64.

**701—67.6(452A) Timely filing of returns, reports, remittances, applications, or requests.** The returns, reports, remittances, applications, or requests required under Iowa Code chapter 452A shall be deemed filed within the required time if (1) postpaid, (2) properly addressed, and (3) postmarked on or before midnight of the day on which due and payable. Any return that is not signed and any return which does not contain substantially all of the pertinent information are not considered "filed" until such time as the taxpayer signs or supplies the information to the department. *Miller Oil Company v. Abrahamson*, 252 Iowa 1058, 109 N.W.2d 610 (1961), *Severs v. Abrahamson*, 255 Iowa 979, 124 N.W.2d 150 (1963). The filing of a return within the period prescribed by law and payment of the tax required to be shown thereon are simultaneous acts, unless remittance is required to be transmitted electronically; and if either condition is not met, a penalty will be assessed. Remittances transmitted electronically are considered to have been made on the date the remittance is added to the bank account designated by the treasurer of the state of Iowa. If the final filing date falls on a Saturday, Sunday, or legal holiday, the next secular or business day is the final filing date. The director may require by rule that reports and returns be filed by electronic transmission. Effective for returns due after July 1, 2006, all licensees must file returns by electronic transmission. All suppliers, restricted suppliers, importers, terminals, blenders, and nonterminal storage facilities with at least 5,000 gallons of product on their return or report must also file the schedules which support the return or report by electronic transmission.

All returns, reports, remittances, applications, or requests should be mailed to: Iowa Department of Revenue, Motor Fuel Unit, Hoover State Office Building, Des Moines, Iowa 50319, unless electronic transmission is required.

In the event a dispute arises as to the time of filing, or a return, report, or remittance is not received by the department, the provisions of Iowa Code section 622.105 are controlling. This rule applies only when the document is not received or the postmark on the envelope is illegible, erroneous, or omitted.

This rule is intended to implement Iowa Code sections 452A.8 and 452A.61.

**701—67.7(452A) Extension of time to file.** The department may grant an extension for the filing of any required return or tax payment or both.

In order for an extension to be granted, the application requesting the extension must be filed, in writing, with the department prior to the due date of the return or remittance. In determining whether an application for extension is timely filed, the provisions of rule 701—67.6(452A) shall apply. The application for extension must be accompanied by an explanation of the circumstances justifying such extension, and in no event will the extension period exceed 30 days.

In the event an extension is granted, the penalties under Iowa Code section 452A.65 applicable to late-filed returns or remittances will not accrue until the expiration of the extension period, but the interest on tax due under the same section will accrue as of the original filing date.

This rule is intended to implement Iowa Code section 452A.61.

**701—67.8(452A) Penalty and interest.** See rules 701—10.6(421) and 701—10.2(421) for failure to timely file a return or for failure to timely pay the tax. See rule 701—10.8(421) for penalty exceptions. See rule 701—10.72(452A) for interest on refunds.

**701—67.9(452A) Penalty and enforcement provisions.** See rule 701—10.71(421).

**701—67.10(452A) Application of remittance.** All payments are to be first applied to the penalty and then to the interest, and the balance, if any, to the amount of tax then due. If a taxpayer remits a payment on or before the due date, but the payment is insufficient to discharge the tax liability, the entire amount of the payment applies to the tax, and the penalty and interest are based on the unpaid portion of the tax. If the department determines there is additional tax due from a taxpayer, interest and penalty shall accrue on that amount from the date it should have been reported and paid.

This rule is intended to implement Iowa Code section 452A.59 as amended by 1995 Iowa Acts, chapter 155, and Iowa Code sections 452A.65 and 452A.66.

**701—67.11(452A) Reports, returns, records—variations.** The department will prescribe and furnish forms upon which reports, returns, and applications are to be made to the department under Iowa Code chapter 452A. Claims for refund will be made on forms provided by the department or in any other manner as prescribed by the director. Licensees may substitute forms for their use, other than official forms, if all the requirements in department rule 701—8.3(17A) are met.

If the information required in these documents is presented to the department on forms or in a manner other than the prescribed form, or approved substitute form, the return, application, or claim for refund or credit shall not be deemed “filed.” The forms may be furnished by the department (except those pertaining to division III interstate operations which are available from the department of transportation) and, therefore, the fact that the reporting party does not have the prescribed form is not an excuse for failure to file.

The department may also prescribe the form of the records which the reporting parties are required to keep in support of the reports/returns they file. The department may approve the form of the records which are being kept by any reporting party and must approve the form of record being kept if that form contains all of the information on the prescribed form, the information is compiled in such a manner as to make it easily ascertainable by department personnel, and substantially complies with the prescribed form.

This rule is intended to implement Iowa Code section 452A.60 as amended by 1999 Iowa Acts, Senate File 136.

**701—67.12(452A) Form of invoice.** Whenever an invoice is required to be kept or prepared by Iowa Code chapter 452A, the invoice must:

1. Be prepared by someone other than the purchaser and include the seller’s name, address, and identification number.
2. Include the purchaser’s name and address.
3. Contain a serial number of three or more digits.
4. Include the calendar date of purchase.
5. Indicate the type of fuel purchased. Diesel fuel must be designated as dyed or undyed.
6. Indicate the quantity of fuel purchased in gross gallons.
7. Indicate the total purchase price and show separately the amount of state and federal fuel tax included in the purchase price or include a statement that all state and applicable federal taxes are included in the purchase price.
8. For ethanol blended gasoline or biodiesel blended fuel, state its designation as provided in Iowa Code section 214A.2.

9. Be prepared on paper which will prevent erasure or alteration or on another form approved by the department.

This rule is intended to implement Iowa Code section 452A.10, section 452A.12 as amended by 2009 Iowa Acts, Senate File 478, section 140, and section 452A.60.  
[ARC 8225B, IAB 10/7/09, effective 11/11/09]

**701—67.13(452A) Credit card invoices.** Credit card invoices are acceptable if they meet substantially all the requirements of rule 701—67.12(452A). (1968 O.A.G. 592)

For refund purposes, presentation of a credit card invoice or billing statement is prima facie evidence that the fuel tax has been paid.

This rule is intended to implement Iowa Code section 452A.60 as amended by 1995 Iowa Acts, chapter 155.

**701—67.14(452A) Original invoice retained by purchaser—certified copy if lost.** Whenever an invoice is required to be kept under Iowa Code chapter 452A, it must be the original copy which is kept. If the original copy is either lost or destroyed, a copy, certified by the seller as being a true copy of the original, will be acceptable. A copy of any invoice which is required to be kept by the purchaser must be kept by the seller for the same period of time.

This rule is intended to implement Iowa Code sections 452A.10 and 452A.60 as amended by 1995 Iowa Acts, chapter 155.

**701—67.15(452A) Taxes erroneously or illegally collected.** Licensees, including licensed suppliers, restrictive suppliers, importers, and blenders, are entitled to a return of taxes, penalty, and interest erroneously or illegally collected by the department. The request for the return of the taxes must be (1) in writing, (2) filed with the department within one year of the time the tax was paid if paid prior to July 1, 2002, and within three years of the time the tax was paid if the tax was paid on or after July 1, 2002, (3) filed by the licensee who remitted the tax to the department, and (4) accompanied by documentation supporting the claim for refund. If the erroneous collection was the result of a computational error on the part of the taxpayer and that error is discovered by the department during an examination of the taxpayer's records within three years of the overpayment, the taxes will be refunded and a written request will not be necessary. If the request includes the return of erroneously or illegally collected (assessed) penalty or interest, the interest or penalty shall be refunded in the same proportion as the tax. A refund requested under Iowa Code section 452A.72 will be reduced by sales tax if applicable. There is no minimum refund amount for refunds claimed under the provisions of Iowa Code section 452A.72. See sales tax rule 701—18.37(422,423).

**67.15(1)** Motor fuel and undyed special fuel suppliers must inform the department upon which bill(s) of lading, by number, and upon which monthly return(s) the tax was erroneously paid. The gallonage upon which a refund is requested on motor fuel or undyed special fuel must be reduced by the distribution allowance provided in Iowa Code section 452A.5. An amended return must be filed for the tax period in which the error occurred.

**67.15(2)** Restrictive suppliers, importers, and blenders must inform the department upon which bill(s) of lading or invoice, by number, and upon which monthly or semimonthly return(s) the tax was erroneously paid and an explanation of the erroneous payment. An amended return must be filed for the tax period in which the error occurred.

This rule is intended to implement Iowa Code section 452A.72 as amended by 2002 Iowa Acts, Senate File 2305.

**701—67.16(452A) Credentials and receipts.** Employees of the department have official credentials, and the taxpayer should require proof of the identity of persons claiming to represent the department. No charges are to be made nor gratuities of any kind accepted by an employee of the department for assistance given in or out of the office of the department.

All employees authorized to collect money are supplied with official receipt forms. When cash is paid to an employee of the department, the taxpayer should require the employee to issue an official

receipt. Such receipt must show the taxpayer's name, address, and permit or license number; the purpose of the payment; and the amount of the payment. The taxpayer should retain all receipts, and the only receipts which the department will accept as evidence of a cash payment are the official receipts.

This rule is intended to implement Iowa Code section 452A.59 as amended by 1995 Iowa Acts, chapter 155.

**701—67.17(452A) Information confidential.** Iowa Code section 452A.63, which makes all information obtained from reports, returns, or records required to be filed or kept under Iowa Code chapter 452A confidential, applies generally to the director, deputies, auditors, agents, officers, or other employees of the department. The information may be divulged to the appropriate public officials enumerated in Iowa Code section 452A.63. These public officials include (1) member(s) of the Iowa General Assembly, (2) committees of either house of the Iowa legislature, (3) state officers, (4) persons who have responsibility for the enforcement of Iowa Code chapter 452A, (5) officials of the federal government entrusted with enforcement of federal motor vehicle fuel tax laws, and (6) officials of other states who have responsibility to enforce motor vehicle fuel tax laws and who will furnish like information to the department. An exception to this rule is that the appropriate state agency may make available to the public the total gallons of motor fuel, undyed special fuel, and ethanol-blended gasoline withdrawn from terminals or imported into the state by suppliers, restrictive suppliers, and importers. The public request must be made within 45 days following the last day of the month in which the tax is required to be paid. See rule 701—6.3(17A) for procedures for requesting information.

This rule is intended to implement Iowa Code section 452A.63 as amended by 1999 Iowa Acts, Senate File 136.

**701—67.18(452A) Delegation to audit and examine.** Pursuant to statutory authority, the director of revenue delegates to the coadministrators of the compliance division the power to examine reports, returns, and records, make audits, and determine the correct amount of tax, interest, penalties, and fines due, and to take all actions authorized to collect the same, subject to review by or appeal to the director of revenue. The power so delegated may further be delegated by the coadministrators of the division to auditors, clerks, examiners, and employees of the division.

This rule is intended to implement Iowa Code sections 452A.62 and 452A.76.

**701—67.19(452A) Practice and procedure before the department of revenue.** The practice and procedure before the department is governed by Iowa Code chapter 17A and 701—Chapter 7.

This rule is intended to implement Iowa Code chapter 17A.

**701—67.20(452A) Time for filing protest.** Any person wishing to contest an assessment, denial of all or any portion of a refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding, must file a protest with the clerk of the hearings section for the department pursuant to rule 701—7.8(17A) within 60 days of the issuance of the assessment, denial, or other department action contested. If a taxpayer failed to timely appeal a notice of assessment, the taxpayer may make payments pursuant to rule 701—7.8(17A) and file a refund claim within the period provided by law for filing claims.

This rule is intended to implement Iowa Code section 452A.64.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

**701—67.21(452A) Bonding procedure.** The director may, when necessary and advisable in order to secure the collection of the tax, require any person subject to the tax to file with the department a bond in an amount as the director may fix, or in lieu of the bond, securities approved by the director in an amount as the director may prescribe. Pursuant to the statutory authorization in Iowa Code sections 422.52(3) and 452A.66, the director has determined that the following procedures will be instituted with regard to bonds:

**67.21(1)** *When required.*

*a.* Classes of business. When the director determines, based on departmental records, other state or federal agency statistics, or current economic conditions, that certain segments of the petroleum business community are experiencing above average financial failures such that the collection of the tax might be jeopardized, a bond or security will be required from every licensee operating a business within this class unless it is shown to the director's satisfaction that a particular licensee within a designated class is solvent and that the licensee previously timely remitted the tax. If the director selects certain classes of licensees for posting a bond or security, rule making will be initiated to reflect a listing of the classes in the rules.

*b.* New applications for fuel tax permits. Notwithstanding the provisions of paragraph "a" above, the director has determined that importers will be required to post a bond in the amount of \$25,000 and other applicants for a new fuel tax permit will be requested to post a bond or security if (1) it is determined upon a complete investigation of the applicant's financial status that the applicant would likely not be able to timely remit the tax, or (2) the new applicant held a prior fuel tax license and the remittance record of the tax under the prior license falls within one of the conditions in paragraph "c" below, or (3) the department experienced collection problems while the applicant was engaged in business under the prior license, or (4) the applicant is substantially similar to a person who would have been required to post a bond under the guidelines as set forth in "c" or such person had a previous fuel tax permit revoked. The applicant is "substantially similar" to the extent that said applicant is owned or controlled by persons who owned or controlled the previous licensee. For example, X, a corporation, had a previous fuel tax permit revoked. X is dissolved and its shareholders create a new corporation, Y, which applies for a fuel tax permit. The persons or stockholders who controlled X now control Y. Therefore, Y will be requested to post a bond or security.

*c.* Existing licensees—amount of bond or security. The simultaneous late filing of the return and the late payment of the tax will count as one delinquency. See rule 701—67.24(452A). However, the late filing of the return or the late payment of the tax will not count as a delinquency if the license holder can satisfy one of the conditions set forth in Iowa Code section 421.27, penalty waiver.

(1) Suppliers will be requested to post a bond or security when they have had one or more delinquencies in remitting the fuel tax or timely filing monthly returns during the past six months.

The bond or security will be an amount sufficient to cover six months' fuel tax liability or \$5,000, whichever is greater.

(2) Restrictive suppliers will be requested to post a bond or security when they have had two or more delinquencies in remitting the fuel tax or timely filing monthly returns during the past 12 months.

The bond or security will be an amount sufficient to cover 12 months' fuel tax liability or \$2,000, whichever is greater.

(3) Blenders will be requested to post a bond or security when they have had two or more delinquencies in remitting the fuel tax or timely filing monthly returns during the past six months.

The bond or security will be an amount sufficient to cover 12 months' fuel tax liability or \$2,000, whichever is greater.

(4) Compressed natural gas, liquefied natural gas, and liquefied petroleum gas dealers and users will be requested to post a bond or security when they have had two or more delinquencies in remitting the fuel tax or timely filing monthly returns during the past 12 months. The bond or security will be an amount sufficient to cover 12 months' fuel tax liability or \$500, whichever is greater.

*d.* Eligible purchasers and end users will be required to post a bond or security when they have failed to pay the tax to a supplier. They will not be allowed to register as an eligible purchaser or end user again until the bond or security requirement has been complied with.

The bond or security will be an amount sufficient to cover six months' fuel tax based on previous purchases.

*e.* Waiver of bond. If a licensee has been requested to post a bond or security or if an applicant for a license has been requested to post a bond or security, upon the filing of the bond or security if the licensee maintains a good filing record for a period of two years, the licensee may request that the department waive the continued bond or security requirement. Importer bonds will not be waived.

**67.21(2) *Type of security or bond.*** When it is determined that a licensee or applicant for a fuel tax permit is required to post collateral to secure the collection of the fuel tax, the following types of collateral will be considered as sufficient: cash, surety bonds, securities, or certificates of deposit. “Cash” means guaranteed funds including, but not limited to, cashier’s check, money order, or certified check. If cash is posted as a bond, the bond will not be considered filed until the final payment is made, if paid in installments. A certificate of deposit must have a maturity date of 24 months from the date of assignment to the department. An assignment from the bank must accompany the original certificate of deposit filed with the department for the bank to be released from liability. When a licensee elects to post cash rather than a certificate of deposit as a bond, conversion to a certificate of deposit will not be allowed. When the licensee is a corporation, an officer of the corporation may assume personal responsibility for the payment of fuel tax. Security requirements for the officer will be evaluated as provided in 67.21(1) above as if the officer applied for a fuel tax license as an individual.

This rule is intended to implement Iowa Code sections 422.52(3) and 452A.66.  
[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—67.22(452A) Tax refund offset.** The department may apply any fuel tax refund against any other liability outstanding.

This rule is intended to implement Iowa Code sections 452A.17 and 421.17.

**701—67.23(452A) Supplier, restrictive supplier, importer, exporter, blender, dealer, or user licenses.**

**67.23(1) *Requirements for license.*** In order to become licensed as a fuel supplier, restrictive supplier, importer, exporter, blender, dealer, or user, the person must file a written application with the department. The license is valid until revoked or canceled, and is nonassignable. The application is to include, but not be limited to, the following information:

- a. The name under which the licensee will transact business in the state.
- b. The location of the principal place of business of the licensee and the mailing address if different.
- c. The social security number or federal identification number of the licensee.
- d. The type of ownership.
- e. The name and complete residency address of the owner(s) of the business or, if a corporation or association, the names and addresses of the principal officers.
- f. The type of license being requested.
- g. Exporters only — the state and license number for that state in which the fuel is being exported.
- h. The signature of the person making the application. For electronically transmitted applications, the application form shall state that, in lieu of the person’s handwritten signature, the person’s E-mail address or the person’s fax signature will constitute a valid signature.

**67.23(2) *Assignment of a license.*** The following are nonexclusive situations that are considered assignments, and the acquiring person must apply for a new license.

- a. A sale of the taxpayer’s business, even if the new owner operates under the same name.
- b. A change of the name under which the licensee conducts business.
- c. A merger or other business combination which results in a new or different entity.

**67.23(3) *Denial of a license.*** The department may deny a license to any applicant who is, at the time of application, substantially delinquent in paying any tax due which is administered by the department or the interest or penalty on the tax and will deny a permit of an individual if the department has received a certificate of noncompliance from the child support recovery unit in regard to an individual. If the applicant is a partnership, a license may be denied if a partner is substantially delinquent in paying any tax, penalty, or interest regardless of whether the tax is in any way a liability of or associated with the partnership. If an applicant for a license is a corporation, the department may deny the applicant a license if any officer with a substantial legal or equitable interest in the ownership of the corporation owes any delinquent tax, penalty, or interest of the applicant corporation. See rule 701—13.16(422) for

a characterization of the terms “tax administered by the department” and “substantially delinquent” in paying a tax. If the application for a license is denied, see rule 701—7.23(17A) for rights to appeal.

**67.23(4) *Revocation of a license.*** The department may revoke the license of any licensee who becomes substantially delinquent in paying any tax which is administered by the department or the interest or penalty on the tax and will revoke a license of an individual if the department has received a certificate of noncompliance from the child support recovery unit in regard to an individual. If a licensee is a corporation, the department may revoke the license if any officer with a substantial legal or equitable interest in the ownership of the corporation owes any delinquent tax, penalty, or interest of the applicant corporation. If the licensee is a partnership, the license may not be revoked for a partner’s substantial delinquency in paying any tax, penalty, or interest which is not a liability of the partnership. See rule 701—13.16(422) for characterizations of the terms “tax administered by the department” and “substantially delinquent” in paying a tax. The department may also revoke the license of any licensee who abuses the privileges for which the license was issued, who files a false return, or who fails to file a return (including supporting schedules), pay the full amount of tax due, produce records requested, or extend cooperation to the department. See rule 701—7.55(17A) for rights to appeal.

**67.23(5) *Efficient administration of motor fuel laws.*** When in the opinion of the director it is necessary for the efficient administration of Iowa Code chapter 452A, the director may regard persons or facilities in possession of motor fuel, special fuel, biofuel, alcohol, or alcohol derivative substances as blenders, dealers, eligible purchasers, exporters, importers, restrictive suppliers, suppliers, terminal operators, or nonterminal storage facility operators. The department will notify the person or facility of the various requirements under the motor fuel tax laws and will ensure that a license is issued.

This rule is intended to implement Iowa Code sections 452A.4 and 452A.6.  
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

**701—67.24(452A) *Reinstatement of license canceled for cause.*** A license canceled for cause will be reinstated only on such terms and conditions as the cause may warrant. Terms and conditions will include payments of any applicable fuel tax liability including interest and penalty which is due the department.

Pursuant to the director’s statutory authority in Iowa Code section 452A.68 to restore licenses after being canceled for cause, the director has determined that upon the cancellation of a motor vehicle fuel tax license the initial time, the licensee will be required to pay all delinquent fuel tax liabilities including interest and penalty, to file returns, and to post a bond and have refrained from activities requiring a license under sections 452A.4 and 452A.6 during the waiting period as required by the director prior to the reinstatement or issuance of a new motor vehicle fuel tax license.

As set forth above, the director may impose a waiting period during which the licensee must refrain from activities requiring a license pursuant to the penalties provided in Iowa Code section 452A.74 for a period not to exceed 90 days as a condition for the restoration of a license or the issuance of a new license after cancellation for cause. The department may require a statement that the licensee has fulfilled all requirements of said order canceling the license for cause and the dates on which the license holder refrained from restricted activities.

Each of the following situations will be considered one offense for the purpose of determining the waiting period to reinstate a license canceled for cause or issuing a new license after being canceled for cause unless otherwise noted.

Failure to post a bond as required.

Failure to file a report or return timely.

Failure to pay tax timely (including unhonored payments, failure to pay and late payments).

Failure to file a return and pay tax as shown on the return (counts as one offense).

The hearing officer or director of revenue may order a waiting period after the cancellation for cause not to exceed:

Five days for one through five offenses.

Seven days for six or seven offenses.

Ten days for eight or nine offenses.

Thirty days for ten offenses or more.

The hearing officer or director of revenue may order a waiting period not to exceed:

Forty-five days if the second cancellation for cause occurs within 24 months of the first cancellation for cause.

Sixty days if the second cancellation for cause occurs within 18 months of the first cancellation for cause.

Ninety days if the second cancellation for cause occurs within 12 months of the first cancellation for cause.

Ninety days if the third cancellation for cause occurs within 36 months of the second cancellation for cause. See 701—subrule 7.24(1) for rights to appeal.

This rule is intended to implement Iowa Code section 452A.68 as amended by 1999 Iowa Acts, Senate File 136.

**701—67.25(452A) Fuel used in implements of husbandry.** Dyed special fuel is exempt from tax. Motor fuel or undyed special fuel is subject to refund when used in implements of husbandry as defined in Iowa Code section 321.1(32). A vehicle as defined in Iowa Code section 321.1(90) is not an implement of husbandry. The department of revenue, the state department of transportation, the department of public safety, and any other peace officer as requested by such department is empowered to enforce the use of special fuel or motor fuel in any illegal manner, including the inspection and testing of fuel in the fuel supply tank of an implement of husbandry.

This rule is intended to implement Iowa Code section 452A.76 as amended by 1995 Iowa Acts, chapter 155.

**701—67.26(452A) Excess tax collected.** If a licensee collects tax on exempt fuel or collects more tax than is due, the licensee must return the excess tax paid to the purchaser if the tax has not been paid to the department. If the tax has been paid to the department, the department will return the excess tax paid to the consumer upon appropriate documentation.

This rule is intended to implement 1999 Iowa Acts, Senate File 136, section 66.

**701—67.27(452A) Retailer gallons report.** The department is required to compile information reported to it by retail dealers regarding the number of gallons of the various fuel classifications sold by retail dealers in the previous calendar year and submit a report to the governor and the legislative services agency by April 1 of each year. Each retail dealer is required to file a report with the department detailing the number of motor fuel gallons sold during the previous calendar year on both a companywide basis and a site-by-site basis as required by the department. The retail dealer report is due by January 31 following the close of the calendar year.

The report filed by the department will include information in the aggregate relating to total sales of gasoline, ethanol blended gasoline, diesel fuel and biofuels. The report will also include appropriate percentage sales of various fuel products. The report will not include individual retail dealer information, trade secret information or confidential information.

This rule is intended to implement Iowa Code section 452A.33 as amended by 2011 Iowa Acts, Senate File 531.

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CHAPTER 68  
MOTOR FUEL AND UNDYED SPECIAL FUEL  
[Prior to 1/1/96, see 701—Ch 64]

**701—68.1(452A) Definitions.** See 701—67.1(452A).

**701—68.2(452A) Tax rates—time tax attaches—responsible party.**

**68.2(1)** The following rates of tax apply to the use of fuel in operating motor vehicles and aircraft:

Gasoline	20.3¢ per gallon (for July 1, 2003, through June 30, 2004)
	20.5¢ per gallon (for July 1, 2004, through June 30, 2005)
	20.7¢ per gallon (for July 1, 2005, through June 30, 2006)
	21¢ per gallon (for July 1, 2006, through June 30, 2007)
	20.7¢ per gallon (for July 1, 2007, through June 30, 2008)
	21¢ per gallon (for July 1, 2008, through June 30, 2015)
LPG	20¢ per gallon
Ethanol blended gasoline	19¢ per gallon (for July 1, 2003, through June 30, 2015)
E-85 gasoline	17¢ per gallon beginning January 1, 2006, through June 30, 2007
	19¢ per gallon (for July 1, 2007, through June 30, 2015)
Aviation gasoline	8¢ per gallon
Special fuel (biodiesel, diesel, LNG)	22.5¢ per gallon
Special fuel (aircraft)	3¢ per gallon
CNG	21¢ per gallon

**68.2(2)** Except as otherwise provided in this subrule, until June 30, 2015, this subrule shall apply to the excise tax imposed on each gallon of motor fuel used for any purpose for the privilege of operating motor vehicles in this state. The rate of the excise tax shall be based on the ethanol distribution percentage. The ethanol distribution percentage is the number of gallons of ethanol blended gasoline that is distributed in this state as expressed as a percentage of the number of gallons of motor fuel, excluding aviation gasoline, distributed in this state. The number of gallons of ethanol blended gasoline and motor fuel distributed in this state shall be based on the total taxable gallons of ethanol blended gasoline and motor fuel as shown on the fuel tax monthly reports issued by the department for January through December for each determination period. The department shall determine the percentage for each determination period beginning January 1 and ending December 31. The rate for the excise tax shall apply for the period beginning July 1 and ending June 30 following the end of the determination period. The rate for the excise tax shall be as follows:

<u>Ethanol Distribution %</u>	<u>Ethanol Tax</u>	<u>Gasoline Tax</u>
00/50	19.0	20.0
50+/55	19.0	20.1
55+/60	19.0	20.3
60+/65	19.0	20.5
65+/70	19.0	20.7
70+/75	19.0	21.0
75+/80	19.3	20.8
80+/85	19.5	20.7
85+/90	19.7	20.4
90+/95	19.9	20.1
95+/100	20.0	20.0

Except as otherwise provided in this subrule, after June 30, 2015, an excise tax of 20 cents is imposed on each gallon of motor fuel used for any purpose for the privilege of operating motor vehicles in this state.

**68.2(3)** The tax attaches when the fuel is withdrawn from a terminal or imported into Iowa. The tax is payable to the department by the supplier, restrictive supplier, importer, blender, or any person who owns the fuel at the time it is brought into the state by a restrictive supplier or importer or any other person who possesses taxable fuel upon which the tax has not been paid. The tax is to be remitted to the department by a supplier, restrictive supplier, or blender by the last day of the month following the month in which the fuel is withdrawn from a terminal or imported. The tax is to be remitted by an importer by the last day of the month for fuel imported in the first 15 days of the month and by the fifteenth day of the following month for fuel imported after the fifteenth day of the previous month. Nonlicensees who possess taxable fuel upon which the tax has not been paid must file returns and pay the tax the same as a restrictive supplier (monthly). All licensees must make payment by electronic funds transfer (see publication 90-201 for EFT requirements).

**68.2(4)** The department shall determine the actual tax paid for E-85 gasoline in the previous calendar year and compare this amount to the amount that would have been paid using the tax rate imposed in Iowa Code section 452A.3, subsection 1 or 1A. If the difference is less than \$25,000, the tax rate for the tax period beginning the following July 1 shall be 17¢ per gallon. If the difference is \$25,000 or more, the tax rate shall be the rate in effect pursuant to Iowa Code section 452A.3, subsection 1 or 1A.

Beginning January 1, 2006, retailers of E-85 gasoline must file a report with the department by the last day of the month of each calendar quarter for each retail location showing the number of invoiced gallons of E-85 gasoline sold by the retailer in Iowa during the preceding calendar quarter. The report must also include a listing of the vendors providing E-85 gasoline to the retailer and the number of gallons received from each vendor. If the retailer blends E-85 gasoline, the retailer must show the number of gallons of motor fuel (including both gasoline and alcohol) purchased and blended. The report must be signed under penalty for false certificate.

**68.2(5)** Persons having title to motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas in storage and held for sale on the effective date of an increase in the excise tax rate imposed on motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas shall be subject to an inventory tax based upon the gallonage in storage as of the close of the business day preceding the effective date of the increased excise tax rate of motor fuel, ethanol blended gasoline, undyed special fuel, compressed natural gas, liquefied natural gas, or liquefied petroleum gas which will be subject to the increased excise tax rate.

Persons subject to the tax imposed under this subrule shall take an inventory to determine the gallonage in storage for purposes of determining the tax and shall report the gallonage and pay the tax due within 30 days of the prescribed inventory date.

The amount of the inventory tax is equal to the inventory tax rate times the gallonage in storage. The inventory tax rate is equal to the increased excise tax rate less the previous excise tax rate. The inventory tax does not apply to an increase in the tax rate of a specified fuel, except for compressed natural gas, unless the increase in the tax rate of that fuel is in excess of one-half cent per gallon.

This rule is intended to implement Iowa Code sections 452A.3, 452A.8 and 452A.85.

[ARC 8225B, IAB 10/7/09, effective 11/11/09; ARC 0399C, IAB 10/17/12, effective 11/21/12; ARC 1442C, IAB 4/30/14, effective 6/4/14; ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—68.3(452A) Exemption.** Motor fuel or undyed special fuel sold for export or exported from this state to another state, territory, or foreign country is exempt from the excise tax. The fuel is deemed sold for export or exported only if the bill of lading or manifest indicates that the destination of the fuel withdrawn from the terminal is outside the state of Iowa. The mode of transportation is not of consequence. In the event fuel is taxed and then subsequently exported, an amount equal to the tax previously paid will be allowable as a refund, upon receipt by the department of the appropriate documents, to the party who originally paid the tax. If the sale of exported fuel is completed in Iowa,

then the sale is subject to Iowa sales tax if it is not exported for resale or otherwise exempt from sales tax. The sale is completed in Iowa if the foreign purchaser takes physical possession of the fuel in this state. *Dodgen Industries, Inc. v. Iowa State Tax Commission*, 160 N.W.2d 289 (Iowa 1968). See sales tax rule 701—18.37(422,423).

Indelible dye meeting United States Environmental Protection Agency and Internal Revenue Service regulations must be added to fuel before or upon withdrawal at a terminal or refinery rack for that fuel to be exempt from tax and the dyed fuel can only be used for a nontaxable purpose listed in Iowa Code section 452A.17, subsection 1, paragraph “a.” However, this exemption does not apply to fuel used for idle time, power takeoffs, reefer units, or pumping credits, or fuel used by contract carriers.

This rule is intended to implement Iowa Code section 452A.3 as amended by 1995 Iowa Acts, chapter 155.

**701—68.4(452A) Ethanol blended gasoline taxation—nonterminal location.**

**68.4(1)** Blenders who own the alcohol (supplier) being used to blend with gasoline must purchase the gasoline from a supplier and pay the appropriate tax to the supplier (20¢ per gallon). The blender must obtain a blender’s license and compute the tax due on the total gallons of blended product and make payment to the department for the additional amount due. For purposes of this subrule and subrules 68.4(2) and 68.4(3), the tax rate for gasoline is presumed to be 20¢ per gallon and the tax rate for ethanol blended gasoline is presumed to be 19¢ per gallon. The actual tax rate for the appropriate period is shown in subrule 68.2(1).

EXAMPLE:

Blender purchases 7,200 gallons tax-paid gasoline ( $7,200 \times .20$ ) =	\$1,440.00
Blender adds 800 gallons untaxed alcohol	.00
Total tax paid on products	\$1,440.00
Total tax due on 8,000 gallons blended product ( $8,000 \times .19$ ) =	<u>\$1,520.00</u>
Additional Amount Due	\$ 80.00

**68.4(2)** Blenders who purchase alcohol and gasoline from a supplier must pay tax of \$.19 per gallon on the alcohol purchased and \$.20 per gallon on the gasoline purchased. The blender must obtain a refund permit to receive a refund of the overpayment of tax on the blended product.

EXAMPLE:

Blender purchases 7,200 gallons tax-paid gasoline ( $7,200 \times .20$ ) =	\$1,440.00
Blender purchases 800 gallons tax-paid alcohol ( $800 \times .19$ ) =	152.00
Total Tax Paid on Products	<u>\$1,592.00</u>
Total tax due on 8,000 gallons blended product ( $8,000 \times .19$ ) =	<u>\$1,520.00</u>
Amount of Refund Allowable	\$ 72.00

**68.4(3)** Ethanol blended gasoline—blending errors. For periods beginning July 1, 1978, to June 30, 2000.

Where blending errors occur and an insufficient amount of alcohol has been blended with motor fuel so that the mixture fails to qualify as ethanol-blended gasoline as defined in Iowa Code section 452A.2(6), the tax shall be determined as follows:

*a.* If the amount of the alcohol blended with motor fuel is short by five gallons or less per blend, the alcohol and motor fuel blended is to be considered ethanol-blended gasoline and there will be no penalty or assessment of additional tax.

*b.* If the alcohol and motor fuel mixture is short of alcohol by more than five gallons but the alcohol blended with the motor fuels is short by 1.01 percent or less of such mixture, the motor fuel must be divided for tax purposes into ethanol-blended gasoline and motor fuel containing no alcohol as follows.

That portion of alcohol must be added to motor fuel on the basis of one part alcohol to nine parts motor fuel to determine the portion which is considered ethanol-blended gasoline and have a tax status as such. The portions of motor fuel remaining are to be considered taxable motor fuel subject to tax at the prevailing rate.

c. If the amount of alcohol blended with motor fuel is short by more than 1.01 percent of the total blend, the total blend of motor fuel and alcohol is subject to tax as motor fuel at the prevailing rate of tax.

The following formula will be used to compute blending errors:

Motor fuel  $\div$  9 = required alcohol

Misblended ethanol blended gasoline  $\times$  .0101 = gallons of alcohol tolerance

Required alcohol – actual alcohol is less than or equal to gallons of alcohol short

Actual alcohol  $\times$  9 = motor fuel portion of ethanol-blended gasoline

Motor fuel portion of ethanol-blended gasoline + actual alcohol = ethanol-blended gasoline

Actual motor fuel – motor fuel portion of ethanol-blended gasoline = motor fuel

The following factors are assumed for all examples:

Figures are rounded to the nearest whole gallons; ethanol-blended gasoline taxed at \$.19 per gallon; motor fuel taxed at \$.20 per gallon. Penalty and interest charges are not computed in the examples.

EXAMPLE 1.

Motor fuel	=	8,000 gal.
Alcohol	=	800 gal.
8,000 $\div$ 9	=	889 gal. required alcohol
8,800 $\times$ .0101	=	89 gal. alcohol tolerance
889 – 800	=	89 gal. short of alcohol

89 is equal to 89 which means that the tax is applied according to paragraph “b” above as follows:

800 $\times$ 9	=	7,200 gal. motor fuel portion of ethanol-blended gasoline
7,200 + 800	=	8,000 gal. of ethanol-blended gasoline
8,000 – 7,200	=	800 gal. of motor fuel subject to tax
8,000 gal. of alcohol $\times$ \$.19	=	\$1520 tax on ethanol-blended gasoline
800 gal. of motor fuel $\times$ \$.20	=	\$ 160
TOTAL		\$1680 (\$1520 + \$160)

EXAMPLE 2.

Motor fuel	=	8,000 gal.
Alcohol	=	795 gal.
8,000 $\div$ 9	=	889 gal. required alcohol
8,795 $\times$ .0101	=	89 gal. alcohol tolerance
889 – 795	=	94 gal. short of alcohol

94 is greater than 89 which means that the entire blend is considered motor fuel and the tax is applied according to paragraph “c” above as follows:

8,795 $\times$ \$.20	=	\$1759.00
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## EXAMPLE 3.

Motor fuel	=	8,000 gal.
Alcohol	=	885 gal.
$8,000 \div 9$	=	889 gal. required alcohol
$889 \text{ gal.} - 885 \text{ gal.}$	=	4 gal. short of alcohol

This total blend is considered ethanol blended gasoline because the blend is short by less than 5 gallons. The tax would be as follows:

$$8,885 \text{ gal.} \times \$ .19 = \$1688.15$$

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

**701—68.5(452A) Tax returns—computations.****68.5(1) Supplier—nexus.**

*a.* The fuel tax liability for a supplier is computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel withdrawn from the terminal by the supplier within the state or by the supplier with an Iowa nexus from a terminal outside the state during the preceding calendar month, less deductions for fuel exported in the case of in-state withdrawals and the distribution allowance provided for in Iowa Code section 452A.5.

Tax shall not be paid when the sale of alcohol occurs within a terminal from an alcohol manufacturer to a licensed supplier. The tax shall be paid by the licensed supplier when the invoiced gross gallonage of the alcohol or the alcohol part of the ethanol blended gasoline is withdrawn from a terminal for delivery in this state. This makes the licensed supplier responsible for the tax on both the alcohol and the gasoline portions of the ethanol blended gasoline and for the reporting and accounting of this fuel as ethanol blended gasoline on the supplier report.

*b.* If fuel is withdrawn by a supplier with no nexus in Iowa, but who voluntarily agrees to collect and report the tax, from a terminal outside of Iowa for importation into Iowa, the tax liability is computed in the same manner as in paragraph “a” with the exception that no deduction is allowable for exports.

**68.5(2)** The fuel tax liability for a restrictive supplier is to be computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel imported into Iowa during the preceding calendar month.

**68.5(3)** The fuel tax liability for an importer is computed by multiplying the per gallon fuel tax rate by the total number of invoiced gallons of motor fuel or undyed special fuel imported into Iowa during the applicable reporting period.

**68.5(4)** The tax liability for a nonlicensee is computed the same as a restrictive supplier. If motor fuel or undyed special fuel is exported from this state with no tax paid and subsequently returned to this state because all or a portion of it was not delivered where destined, the tax must be paid to the department by the nonlicensee.

All entries on the return for determining the tax liability must be rounded to the nearest whole number.

This rule is intended to implement Iowa Code section 452A.3 as amended by 2001 Iowa Acts, House File 736, and sections 452A.5, 452A.8, and 452A.9.

**701—68.6(452A) Distribution allowance.** The tax computation for a supplier includes a distribution allowance of 1.6 percent of the motor fuel gallonage and 0.7 percent of the undyed special fuel gallonage removed from the terminal during the reporting period. The distributor purchasing the fuel from the supplier is entitled to 1.2 percent of the motor fuel distribution allowance. The distributor or

dealer purchasing fuel from a supplier is entitled to 0.35 percent of the undyed special fuel distribution allowance. The distribution allowance does not apply to fuel exported.

This rule is intended to implement Iowa Code sections 452A.5 and 452A.8 as amended by 1995 Iowa Acts, chapter 155.

**701—68.7(452A) Supplier credit—uncollectible account.** A licensed supplier who is unable to recover the tax from an eligible purchaser or end user is not liable for the tax and may credit the amount of unpaid tax against a later remittance of tax.

**68.7(1)** To qualify for the credit, the supplier must notify the department in writing of the uncollectible account no later than ten calendar days after the due date for payment of the tax.

Notification is to be sent to the Iowa Department of Revenue, Examination Section, Compliance Division, P. O. Box 10456, Des Moines, Iowa 50306-0456.

**68.7(2)** A supplier does not qualify for the credit if the purchaser did not elect to apply for the eligible purchaser or end user status or did not qualify to be an eligible purchaser. Likewise, the credit does not apply if the supplier sells additional fuel to a delinquent eligible purchaser or end user after notifying the department that the supplier has an uncollectible debt with an eligible purchaser.

**68.7(3)** Upon notification from the supplier that an eligible purchaser is in default of the tax payment, that person's eligible purchaser or end user status will be canceled by the department. The eligible purchaser or end user status will not be reinstated until such time as the purchaser posts securities to guarantee future tax payments as provided in 701—paragraph 67.21(1)“d.”

**68.7(4)** Eligible purchaser. Any distributor of motor fuel or special fuel or end user of special fuel who requests authorization to make delayed payments of the motor vehicle fuel tax must first register with the department to obtain the eligible purchaser status.

The eligible purchaser must pay the tax to the supplier by electronic funds transfer one business day prior to the date the tax is to be paid by the supplier.

Once approved, the eligible purchaser status is valid until voluntarily canceled by the eligible purchaser or canceled by the department of revenue. See 701—subrule 67.23(4).

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

**701—68.8(452A) Refunds.** Refunds are allowable for the tax paid on motor fuel and undyed special fuel in the following situations:

**68.8(1)** Federal government. Fuel sold to the United States or to any agency or instrumentality of the United States. The tax is subject to refund regardless of how the fuel is used. The following factors, among others, will be considered in determining if any organization is an instrumentality of the United States government: (a) whether it was created by the federal government, (b) whether it is wholly owned by the federal government, (c) whether it is operated for profit, (d) whether it is “primarily” engaged in the performance of some “essential” government function, and (e) whether the tax will impose an economic burden upon the federal government or serve to materially impair the usefulness and efficiency of the organization or to materially restrict it in the performance of its duties if it were imposed. *Unemployment Compensation Commission v. Wachovia Bank & Trust Company*, 215 N.C. 491, 2 S.E.2d 592 (1939); 1976 O.A.G. 823, 827. The American Red Cross, Project Head Start, Federal Land Banks and Federal Land Bank Associations, among others, have been determined to be instrumentalities of the federal government. Receivers or trustees appointed in the federal bankruptcy proceedings are subject to the excise tax. *Wood Brothers Construction Co. v. Bagley*, 232 Iowa 902, 6 N.W.2d 397 (1942).

The refund is not available to employees of the federal government who purchase fuel individually and are later reimbursed by the federal government. The name of the federal agency must appear on the invoice as the purchaser of the fuel or the refund will not be allowed.

**68.8(2)** Transit systems. Fuel sold to an Iowa urban transit system as defined in 701—67.1(452A) or a company operating a taxicab service under contract with an Iowa urban transit system which is used for a purpose specified in Iowa Code section 452A.57(6) and fuel sold to a regional transit system as defined in 701—67.1(452A) which is used for a purpose specified in Iowa Code section 452A.57(11).

**68.8(3)** The state and political subdivisions. Fuel sold to the state of Iowa or any political subdivision of the state which is used for public purposes.

The refund is not available to agencies or instrumentalities of a political subdivision, but rather only to the state of Iowa, agencies of the state of Iowa, and political subdivisions of the state of Iowa. The general attributes and factors in determining if an entity is a political subdivision of the state of Iowa are: (a) the entity has a specific geographic area, (b) the entity has public officials elected at public elections, (c) the entity has taxing power, (d) the entity has a general public purpose or benefit, and (e) the foregoing attributes, factors or powers were delegated to the entity by the state of Iowa. (1976 O.A.G. 823)

The refund is also not available to employees of a governmental unit who purchase fuel individually and are later reimbursed by the governmental unit. The name of the governmental unit must appear on the invoice as the purchaser of the fuel or the refund will not be allowed. *Alabama v. King & Boozer*, 314 U.S. 1 (1941).

**68.8(4)** Contract carriers. Motor fuel and undyed special fuel sold to a contract carrier who has a contract with a public school under Iowa Code section 285.5 for the transportation of pupils of an approved public or nonpublic school is refundable. If the contract carrier also uses fuel for purposes other than the transportation of pupils, the refund will be based on that percentage of the total amount of fuel purchased which reflects the pupil transportation usage.

A refund requested by contract carriers will be reduced by the applicable sales tax unless otherwise exempt. The name of the contract carrier must appear on the invoice as the purchaser of the fuel or the refund will not be allowed. *Alabama v. King & Boozer*, 314 U.S. 1 (1941).

**68.8(5)** Fuel used in unlicensed vehicles, stationary engines, machinery and equipment used for nonhighway purposes, implements used in agricultural production, and fuel used for home heating.

**68.8(6)** Fuel used for producing denatured alcohol.

**68.8(7)** Fuel used in the watercraft of a commercial fisher, licensed and operating under an owner's certificate for commercial fishing gear issued pursuant to Iowa Code section 482.4.

**68.8(8)** Fuel placed in motor vehicles, whether registered or not registered, not operated on public highways, and used in the extraction and processing of natural deposits.

**68.8(9)** Idle time. Persons who wish to claim a refund for idle time (the engine is running but not propelling the vehicle) must first apply to the department and provide statistical information on how the refund amount will be calculated. Normally, to qualify for a refund the vehicle must be equipped with an on-board monitoring device which will record the actual time the engine is idling and the amount of fuel consumed while idling. If the device only records the idle time and not fuel used, the refund amount will be calculated at one-half gallon of fuel consumed per one hour of idle time. The computation must also consider the miles driven in Iowa versus total miles driven. The department will require a review of interstate carrier reports before approval of the computation method.

**68.8(10)** Power takeoff. Persons operating vehicles which have auxiliary equipment that is powered by the power takeoff may apply for a refund for that portion of the fuel used for powering the auxiliary equipment.

The person requesting the refund must furnish the department with statistical information on how the exempt percentage is established. The percentage can be established by using the following noninclusive methods.

- Determine the actual fuel usage by the hour while the auxiliary equipment is in use compared to total hours the engine is running.
- Establish total miles per gallon for the vehicle when auxiliary equipment is not in use compared to miles per gallon while the equipment is in use.
- Other computation methods to be reviewed by the department prior to approval.

It has been predetermined that tax on fuel used in the mixing of cement into concrete, the off-loading of the concrete, and the loading and off-loading of solid waste will be refunded on the basis of 30 percent of the fuel placed in the fuel supply tank of the vehicle provided proper records are maintained. Proper records shall consist of records of fills for each vehicle from tax-paid bulk storage tanks or sales tickets where fuel is purchased directly from a service station. Each vehicle must be identifiable by a unit number so the department can trace fuel usage to specific vehicles. An additional allowance will be

granted where it can be substantiated through the use of separate meters which operate to measure the fuel when the vehicle is stationary or the use of separate tanks which fuel the vehicle only when the vehicle is stationary that the actual nonhighway fuel usage exceeds 30 percent.

**68.8(11)** Refrigeration units (reefers). Tax paid on motor fuel and undyed special fuel is subject to refund. The person must maintain records of fuel purchases to substantiate the tax-paid purchases. Invoices must meet the criteria set forth in rule 701—67.12(452A). In addition, the invoices must separately state fuel purchased and placed in the reefer unit. Liquefied petroleum gas may be purchased tax-free for use in reefer units. See rule 701—69.10(452A).

**68.8(12)** Pumping credits. A refund will be allowed for taxes paid on fuel once that fuel has been placed in the fuel supply tank of a motor vehicle when the motor of that vehicle is used as a power source for off-loading procedures. Meter readings from the pump used in the off-loading procedure or the invoice, manifest or bill of lading number covering the product off-loaded must be retained. The claims for refund, unless a different amount can be proven, will be (a) one-half gallon credit for each 1,000 gallons of liquid products pumped and three-tenths of a gallon credit for each ton of dry products pumped when using motor fuel or special fuel (diesel) to power the motor and (b) one gallon credit for each 1,000 gallons of liquid products pumped and three-tenths of a gallon credit for each ton of dry products pumped when using special fuel (LPG) to power the motor.

**68.8(13)** Transport diversions. When a transport load of motor fuel or undyed special fuel is sold tax-paid with a destination in this state and later diverted to a destination outside the state, the person who actually paid the Iowa tax is entitled to a refund. To secure a refund, the person must file a completed claim form provided by the department with supporting documentation including a copy of the bill of lading, invoices or document showing where and to whom the fuel was delivered, a copy of the reporting form and evidence of payment to the state where the fuel was actually delivered.

**68.8(14)** Casualty loss. In the event fuel is lost or destroyed through fire, explosion, lightning, flood, storm, earthquake, terrorist attack, or other casualty, the taxpayer must inform the department in writing of such loss within 10 days of the loss; and the notification must contain the amount of gallon-age lost or destroyed which must be in excess of 100 gallons. An application for refund must be submitted to the department within 60 days of the notification and contain a notarized affidavit sworn to by the person having immediate custody of the fuel at the time of the loss or destruction setting forth, in full detail, the circumstances of the loss or destruction and the number of gallons. If the fuel was in storage where several fuel purchases were commingled, it is a rebuttable presumption that the fuel lost through casualty was a part of the last delivery into the storage just prior to the loss. No refund is allowable for fuel lost through evaporation, theft, normal leakage, or unknown causes. Leakage resulting from a major accident or catastrophe is subject to refund.

**68.8(15)** Exports by eligible purchasers (distributors). Distributors who have purchased tax-paid motor fuel or undyed special fuel and sell the fuel to consumers outside the state may apply for a refund of the Iowa tax paid. The distributor must retain records as provided in rule 701—67.3(452A) to support the request for refund.

**68.8(16)** Blending errors for special fuel. Dyed special fuel commingled with undyed special fuel and motor fuel commingled with special fuel. If dyed special fuel is inadvertently mixed with tax-paid undyed special fuel to the extent that the undyed fuel must have additional dye added to meet federal dyeing requirements to qualify as exempt dyed fuel, the tax is refundable on the undyed special fuel. The refund request must contain the number of gallons of undyed fuel lost through the mixing error and documentation as to how the gallonage was determined. If motor fuel is blended in error with dyed special fuel to produce a commingled product that must be destroyed or refined for subsequent use, the tax-paid fuel is subject to refund. The request for refund must contain documentation that the commingled product was destroyed or sold for purposes of refinement at a terminal.

**68.8(17)** Watercraft. Special fuel used in watercraft. This subrule is retroactive to July 1, 1996.

**68.8(18)** Refund of tax—Indians. Sales by Indians to other Indians of their own tribe on federally recognized Indian reservations or settlements of which they are tribal members are exempt from the tax. However, Indian sellers are subject to the record-keeping requirements of Iowa Code chapter 452A. The fuel must be purchased by the Indian seller with the tax included in the purchase price, unless the

seller's status as a particular licensee authorizes the seller to purchase fuel tax-free. The tax exemption is allowed to the Indian purchaser by the purchaser's filing a claim for refund of the tax paid or the tribe of which the Indian purchaser is a member filing a claim for refund of the tax paid by the tribe on fuel sold to the Indian purchaser.

**68.8(19)** Racing fuel.

**68.8(20)** Benefited fire districts if the fuel is used for public purposes.

This rule is intended to implement Iowa Code section 452A.17 as amended by 2005 Iowa Acts, House File 216, and Iowa Code section 452A.71.

**701—68.9(452A) Claim for refund—payment of claim.** In order to receive a refund, the claimant must hold a refund permit.

**68.9(1)** Persons requesting a refund for fuel used for any exempt purpose will do so by providing all or a portion of the following: (a) refund permit number, (b) type of fuel, (c) total number of gallons/tons of fuel used to calculate the refund amount, (d) the beginning and ending dates of the tax period, (e) net cost of fuel, (f) Iowa sales tax due (net cost of fuel times sales tax rate), (g) other items depending on the type of permit and claim type, (h) the total amount of refund claimed, and (i) additional information as required.

Persons requesting a refund for casualty loss, transport diversions, blending errors of motor fuel and alcohol, and blending errors of special fuel must file in writing on the forms provided by the department and must attach supporting documents explaining why a refund is due.

**68.9(2)** Refunds are made and the amount of the refund is paid to the person who actually paid the tax with the following exception: Persons requesting a refund for idle time, power takeoff, reefer units, pumping credits, or transport diversions may designate another person as an agent to file the claim and receive the refund. The person acting as an agent for others must provide the department with the following information including, but not limited to, the name, address, and federal identification number or social security number of the person on whose behalf they are requesting the refund. Once a person is designated as an agent, this designation remains in force until the department is notified in writing the agency agreement no longer exists. A governmental agency may designate another governmental agency as an agent for filing and receiving any tax refund authorized in Iowa Code section 452A.17.

**68.9(3)** Deposit of refund. If the person so designates on the application, the department will direct deposit the refund in the person's designated bank account. If this option is selected on the application, additional forms will be provided to secure the needed information for direct deposit. In lieu of direct deposit, the permit holder will receive a state warrant.

**68.9(4)** A claim for refund will not be allowed unless the claimant has accumulated \$60 in credits for one calendar year. A claim for refund may be filed anytime the \$60 minimum has been met within the calendar year. If the \$60 minimum has not been met in the calendar year, the credit must be claimed on the claimant's income tax return unless the claimant is not required to file an income tax return in which case a refund will be allowed. An income tax credit may not be claimed for any year in which a claim for refund was filed. Once the \$60 minimum has been met, the claim for refund must be filed within one year if met prior to July 1, 2002, and within three years if met on or after July 1, 2002.

EXAMPLE: A claim for refund in the amount of \$200 is filed in March of 1996. During the remainder of 1996 an additional \$50 in credits is accumulated. The claimant cannot claim this \$50 credit on the claimant's 1996 income tax return because an income tax credit cannot be filed for any year in which a claim for refund was filed. The claimant must file a claim for refund of the \$50 even though it is below the \$60 minimum.

EXAMPLE: The claimant does not have a refund permit. The claimant accumulates \$40 in credits during January of 2002 and \$50 in credits during June of 2002. The claimant may claim a \$90 credit on the claimant's 2002 income tax return or apply for a refund permit and claim a refund within one year of June 2002 which is the date the \$60 minimum was met. If the \$60 minimum is met on or after July 1, 2002, the claim for refund must be filed within three years of the date the \$60 minimum was met.

**68.9(5)** A refund will not be paid with respect to any motor fuel taken out of this state in supply tanks of watercraft, aircraft, or motor vehicles or any undyed special fuel taken out of this state in aircraft or motor vehicles.

**68.9(6)** Rescinded IAB 11/3/99, effective 12/8/99.

This rule is intended to implement Iowa Code sections 452A.17, 452A.19, 452A.21, and 452A.72 as amended by 2002 Iowa Acts, Senate File 2305.

**701—68.10(452A) Refund permit.** To obtain the refund provided for in Iowa Code chapter 452A and rule 68.8(452A), the claimant must have an uncanceled refund permit. The application for a refund permit is provided by the department and will contain, but not be limited to, the following information: (1) the name and location of the business and the mailing address if different, (2) the type of ownership, (3) the social security number or federal identification number of the applicant, and (4) the type of refund requested. The refund permit is issued without cost and remains in effect until revoked, canceled or until the permit becomes invalid. All refund permit holders are required to keep invoices and copies of returns if filed, supporting schedules and studies for documentation to support the refund.

This rule is intended to implement Iowa Code section 452A.18 as amended by 1995 Iowa Acts, chapter 155.

**701—68.11(452A) Revocation of refund permit.** The following violations will result in the revocation of the permit: (1) using a false or altered invoice in support of a claim, (2) making a false statement in a claim for refund or in response to an investigation by the department of a claim for refund, (3) refusal to submit the claimant's books and records for examination by the department, and (4) nonuse for a period of three years. If the permit is revoked for reason (1), (2), or (3) above, the permit will not be reissued for a period of at least one year. If the permit is revoked for reason (4) above, the permit will be reissued upon proper application. (See rule 701—7.23(17A) for revocation procedure.)

This rule is intended to implement Iowa Code section 452A.19.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

**701—68.12(452A) Income tax credit in lieu of refund.** In lieu of applying for a refund permit, a person or corporation may claim the refund allowable under Iowa Code section 452A.17 as an income tax credit. If a person or corporation holds a refund permit and elects to receive an income tax credit, the person or corporation must cancel the refund permit within 30 days after the first day of its year or the permit becomes invalid and application must be made for a new permit. Once the election to receive an income tax credit has been made, it remains in effect until the election is changed. The income tax credit is not available for refunds relating to casualty losses, transport diversions, pumping credits, blending errors, idle time, power takeoffs, reefer units, exports by distributors, and excess tax paid on ethanol blended gasoline.

This rule is intended to implement Iowa Code sections 422.110, 452A.17(2), and 452A.21 as amended by 1999 Iowa Acts, Senate File 136.

**701—68.13(452A) Reduction of refund—sales tax.** Under Iowa Code section 422.45(11), the gross receipts from the sale of motor fuel and special fuel consumed for highway use or in watercraft or aircraft where the fuel tax has been imposed and paid and no refund has been or will be allowed are exempt from Iowa sales tax. Therefore, unless the fuel is used for some other exempt purpose under Iowa Code section 422.42(3) or 422.45 (e.g., used for processing, used for agricultural purposes, used by an exempt government entity, used by a private nonprofit educational institution), or the fuel is lost through a casualty, the refund of taxes on motor fuel or special fuel will be reduced by the applicable sales tax. See sales tax rule 701—18.37(422,423). The sale base upon which the sales tax will be applied shall include all federal excise taxes, but will not include the Iowa motor vehicle fuel tax. *W. M. Gurley v. Army Rhoden*, 421 U.S. 200, 44 L.Ed. 110, 95 S.Ct. 1605.

This rule is intended to implement Iowa Code section 452A.17 as amended by 1995 Iowa Acts, chapter 155.

**701—68.14(452A) Terminal withdrawals—meters.** Any refinery or terminal within this state must be fixed with meters which totalize the gross gallons withdrawn. All bills of lading or manifests must show the gross gallons withdrawn. A temperature-adjusted or other method shall not be used except as it applies to liquefied petroleum gas and the sale or exchange of petroleum products between petroleum refiners. All fuel withdrawn from a refinery or terminal within this state must pass through these meters.

This rule is intended to implement Iowa Code sections 452A.2, 452A.8, 452A.15(2), and 452A.59 as amended by 1995 Iowa Acts, chapter 155.

**701—68.15(452A) Terminal and nonterminal storage facility reports and records.** Each terminal and nonterminal storage facility operating in Iowa must file a monthly inventory report with the department. The report shall include, but not be limited to, the following information:

1. The name and license number of the company that owns and operates the terminal or nonterminal storage facility.
2. The location of the terminal or nonterminal storage facility.
3. The month and year covered by the report.
4. The terminal code assigned by the Internal Revenue Service or the storage facility license number assigned by the department.
5. The beginning inventory.
6. The total receipts for the month including for each receipt: (a) the gross gallons received by schedule code, by fuel type and, if diesel fuel, whether dyed or undyed fuel, (b) the bill of lading number, (c) the date of receipt, (d) the seller, (e) the carrier, (f) the mode of transportation, and (g) the destination state.
7. The total withdrawals for the month, including for each withdrawal: (a) the gross gallons withdrawn by schedule code and by fuel type and, if diesel fuel, whether dyed or undyed fuel, (b) the bill of lading number, (c) the date of withdrawal, (d) the consignor, (e) the consignee, (f) the mode of transportation, (g) the destination state, (h) the origin state, and (i) the carrier.
8. The actual ending inventory and any gains or losses.
9. The signature or electronic signature of the person responsible for preparing the report.
10. Such additional information as the department may require.

For periods beginning on or after July 1, 2002, the director may impose a civil penalty against any person who fails to file the reports required under the motor fuel tax laws. The penalty shall be \$100 for the first violation and shall increase by \$100 for each additional violation occurring in the calendar year in which the first violation occurred.

The director may require that reports be filed by electronic transmission. All licensees must file reports by electronic transmission beginning September 1, 2006.

This rule is intended to implement Iowa Code section 452A.15(2).

**701—68.16(452A) Method of reporting taxable gallonage.** The exclusive method of determining gallonage of any purchase or sale of motor fuel or special fuel and distillate fuel is to be on gross-volume basis. A temperature-adjusted or other method cannot be used, except as it applies to liquefied petroleum gas and the sale or exchange of petroleum products between petroleum refineries.

This rule is intended to implement Iowa Code section 452A.8 as amended by 1995 Iowa Acts, chapter 155.

**701—68.17(452A) Transportation reports.** The reports required under Iowa Code section 452A.15(1) are to be filed by railroad carriers, common carriers, contract carriers, distributors transporting fuel for others, and anyone else transporting fuel from without the state and unloading it at other than terminal storage within the state. The report must include all fuel which was imported into Iowa and unloaded at other than terminal storage, all fuel withdrawn from Iowa terminal storage and delivered in Iowa, and all fuel withdrawn from Iowa terminal storage and exported from Iowa. These reports must be filed monthly and show as to each delivery:

1. The name, address, and federal identification number or social security number of the person to whom actually delivered.
2. The name, address, and federal identification number or social security number of the originally named consignee, if delivered to anyone other than the originally named consignee.
3. The point of origin, the point of delivery, and the date of delivery.
4. The number and initials of each tank car and the number of gallons contained therein, if shipped by rail.
5. The name of the boat, barge, or vessel, and the number of gallons contained therein, if shipped by water.
6. The registration number of each tank truck and the number of gallons contained therein, if transported by motor truck.
7. The manner, if delivered by other means, in which the delivery is made.
8. Such additional information relative to shipments of motor fuel or special fuel as the department may require.

For periods on or after July 1, 2002, the director may impose a civil penalty against any person who fails to file the reports required under the motor fuel tax laws. The penalty shall be \$100 for the first violation and shall increase by \$100 for each additional violation occurring in the calendar year in which the first violation occurred.

The director may require that reports be filed by electronic transmission.

This rule is intended to implement Iowa Code section 452A.15 as amended by 2002 Iowa Acts, House File 2622 and Senate File 2305.

**701—68.18(452A) Bill of lading or manifest requirements.** Whenever a bill of lading or manifest is required to be issued, carried, retained, or submitted by these rules, it shall meet the following minimum requirements:

1. Contain the name and address of the refinery, terminal, ethanol plant, biodiesel plant or point of origin.
2. Contain the date of withdrawal or import.
3. Contain the name of the shipper-supplier-consignor.
4. Contain the name of the purchaser-consignee.
5. Contain the place of actual destination.
6. Contain the name of the transporter.
7. Contain the gross gallons by fuel type.
8. Contain the designation for ethanol blended gasoline or biodiesel blended fuel as provided in Iowa Code section 214A.2.
9. Contain a statement designating whether diesel fuel is dyed or undyed.
10. Have machine printed thereon a serial number of not less than four digits.

This rule is intended to implement Iowa Code sections 452A.10, 452A.12, 452A.60, and 452A.76.  
[ARC 8225B, IAB 10/7/09, effective 11/11/09]

**701—68.19(452A) Right of distributors and dealers to blend conventional blendstock for oxygenate blending, gasoline, or diesel fuel using a biofuel.**

**68.19(1)** A dealer or distributor may blend a conventional blendstock for oxygenate blending, gasoline, or diesel fuel using the appropriate biofuel, or sell unblended or blended gasoline or diesel fuel on any premises in this state. This subrule does not apply to the extent that the use of the premises is restricted by federal, state, or local law.

**68.19(2)** A refiner, supplier, terminal operator, or terminal owner who in the ordinary course of business sells or transports a conventional blendstock for oxygenate blending, gasoline unblended or blended with a biofuel, or diesel fuel unblended or blended with a biofuel shall not refuse to sell or transport to a distributor or dealer any conventional blendstock for oxygenate blending, unblended gasoline, or unblended diesel fuel that is at the terminal, based on the distributor's or dealer's intent

to use the conventional blendstock for oxygenate blending, or blend the gasoline or diesel fuel with a biofuel.

**68.19(3)** This rule shall not be construed to do any of the following:

*a.* Prohibit a distributor or dealer from purchasing, selling or transporting a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.

*b.* Affect the blender's license requirements under Iowa Code section 452A.6.

*c.* Prohibit a dealer or distributor from leaving a terminal with a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.

*d.* Require a nonrefiner biofuel manufacturer to offer or sell a conventional blendstock for oxygenate blending, gasoline that has not been blended with a biofuel, or diesel fuel that has not been blended with a biofuel.

**68.19(4)** A refiner, supplier, terminal operator, or terminal owner who violates this rule is subject to a civil penalty of not more than \$10,000 per violation. Each day that a violation continues is deemed a separate offense. For more information on enforcement of this penalty, see 701—subrule 10.71(8).

This rule is intended to implement Iowa Code section 452A.6A.

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CHAPTER 69  
LIQUEFIED PETROLEUM GAS—  
COMPRESSED NATURAL GAS—LIQUEFIED NATURAL GAS

[Prior to 1/1/96, see 701—Ch 65]

**701—69.1(452A) Definitions.** For the purpose of this chapter, the following definitions shall govern:

“*C.N.G.*” shall mean compressed natural gas.

“*Department*” means the department of revenue.

“*Director*” means the director of the Iowa department of revenue or the director’s authorized representative.

“*Distributor*” means any person who sells compressed natural gas or liquefied petroleum gas in bulk for highway use.

“*Gallon*,” with respect to compressed natural gas, means a gasoline gallon equivalent. A gasoline equivalent of compressed natural gas is five and sixty-six hundredths pounds or one hundred twenty-six and sixty-seven hundredths cubic feet measured at a base temperature of 60 degrees Fahrenheit and a pressure of fourteen and seventy-three hundredths pounds per square inch absolute. “*Gallon*,” with respect to liquefied natural gas, means a diesel gallon equivalent. A diesel gallon equivalent of liquefied natural gas is six and six hundredths pounds.

“*Invoiced gallons*” means gross gallons as shown on the bill of lading or invoice. A temperature-adjusted method may be used as it applies to liquefied petroleum gas.

“*Licensed compressed natural gas, liquefied natural gas, and liquefied petroleum gas dealer*” means a person in the business of handling untaxed compressed natural gas, liquefied natural gas, or liquefied petroleum gas who delivers any part of the fuel into a fuel supply tank of any motor vehicle.

“*Licensed compressed natural gas, liquefied natural gas, and liquefied petroleum gas user*” means a person licensed by the department who dispenses compressed natural gas, liquefied natural gas, or liquefied petroleum gas, upon which the special fuel tax has not been previously paid, for highway use from fuel sources owned and controlled by the person into the fuel supply tank of a motor vehicle, or commercial vehicle owned or controlled by the person.

“*Licensed metered pumps or metered pumps*” shall mean pumps which have been metered, inspected, tested for accuracy, sealed and licensed by the state department of agriculture pursuant to Iowa Code section 452A.8(2)“e.”

“*Licensed metered storage or metered storage*” shall mean storage facilities which are fixed with “licensed metered pumps.”

“*L.N.G.*” shall mean liquefied natural gas.

“*L.P.G.*” shall mean liquefied petroleum gas.

“*Owner*” shall mean and include the owner or the employees, agents, or persons under the control of the owner.

“*Special fuel*” means liquefied petroleum gas, liquefied natural gas, or compressed natural gas.

“*Use*” means the receipt, delivery, or placing of liquefied petroleum gas by a licensed liquefied petroleum gas user into a fuel supply tank of a motor vehicle while the vehicle is in the state, except that with respect to natural gas used as a special fuel, “use” means the receipt, delivery, or placing of the natural gas into equipment for compressing the gas for subsequent delivery into the fuel supply tank of a motor vehicle.

In addition to the preceding definitions, applicable definitions contained in Iowa Code section 452A.2 and rule 701—67.1(452A) shall govern the rules in this chapter where applicable.

This rule is intended to implement Iowa Code chapter 452A.

[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.2(452A) Tax rates—time tax attaches—responsible party—payment of the tax.** See 701—subrule 68.2(1) for tax rates. The excise tax on L.P.G. attaches when the special fuel is placed in a fuel supply tank of a motor vehicle. The excise tax on C.N.G. and L.N.G. attaches at the time of delivery into equipment for compressing the gas for subsequent delivery into the fuel supply tank of a

motor vehicle. The person responsible for the tax must collect the tax from the purchaser and remit the tax to the department. The person responsible for the tax is:

1. The licensed L.P.G., L.N.G., or C.N.G. dealer, or
2. The licensed L.P.G., L.N.G., or C.N.G. user.

The person responsible for placing L.P.G. into the fuel supply tank of a vehicle and the person responsible for placing C.N.G. or L.N.G. into compressing equipment must hold a license as a dealer or user as defined in Iowa Code section 452A.4.

The return and tax are due no later than the last day of the month following the month the L.P.G. was placed in a vehicle or C.N.G. or L.N.G. was placed into compressing equipment. The tax must be remitted by means of electronic funds transfer, unless the licensee can show that this method of payment would cause undue hardship on the licensee and must be rounded to the nearest whole number. The return must be remitted by means of electronic transmission.

This rule is intended to implement Iowa Code section 452A.8 as amended by 2014 Iowa Acts, Senate File 2338.

[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.3(452A) Penalty and interest.** See rules 701—10.6(421) and 701—10.2(421) for failure to timely file a return or for failure to timely pay the tax. See rule 701—10.8(421) for penalty exceptions. See rule 701—10.72(452A) for interest on refunds.

**701—69.4(452A) Bonding procedure.**

**69.4(1)** When required, classes of business and new applications for fuel tax permit. See 701—subrule 67.21(1), paragraphs “a” and “b.”

**69.4(2)** Existing license holders. Existing license holders will be requested to post a bond or security when they have had two or more delinquencies in remitting the fuel tax or filing returns timely during the past 12 months when filing returns on a monthly basis. The bond or security will be an amount sufficient to cover 12 months’ fuel tax liability or \$500, whichever is greater. The simultaneous late filing of the return and the late payment of the tax will count as one delinquency. However, the late filing of the return or late payment of the tax will not count as a delinquency if the license holder can satisfy one of the conditions set forth in Iowa Code section 421.27 (penalty waiver). For waiver of bond see 701—paragraph 67.21(1) “e.”

**69.4(3)** Type of security. See 701—subrule 67.21(2).

**701—69.5(452A) Persons authorized to place L.P.G., L.N.G., or C.N.G. in the fuel supply tank of a motor vehicle.** The only persons authorized to place L.P.G., L.N.G., or C.N.G. into the fuel supply tank of a motor vehicle are: licensed L.P.G., L.N.G., or C.N.G. dealers, or licensed L.P.G., L.N.G., or C.N.G. users.

**69.5(1)** *L.P.G., L.N.G., or C.N.G. dealer’s license.* Anyone who delivers L.P.G. into the fuel supply tank of a motor vehicle or places C.N.G. or L.N.G. into compression equipment which tank is owned by some other person must be licensed as an L.P.G., L.N.G., or C.N.G. dealer. A dealer may also fuel the dealer’s own vehicles under this license.

**69.5(2)** *L.P.G., L.N.G., or C.N.G. user’s license.* Anyone who delivers L.P.G., L.N.G., or C.N.G. into the fuel supply tank of a motor vehicle, which tank is owned or leased by the person delivering it, must be licensed as an L.P.G., L.N.G., or C.N.G. user. If that same person delivers the fuel into tanks owned by others, that person must be licensed as a dealer in lieu of being licensed as a user.

**69.5(3)** *L.P.G. “mobile” tank exemption.* When a person has an L.P.G. storage tank which is “mobile” and the storage is moved from location to location, that person may be issued an L.P.G. user’s license. This licensee will be allowed to move the storage tank to a new location without procuring a new license for each new location. The issuance of this license is discretionary with the director, and the license will be issued only when the person requesting the license shows a need for mobile storage. The license will be issued to the licensee at the licensee’s principal place of business, and each mobile storage tank is deemed a separate pump at that location.

The operation of such licensed mobile storage shall be subject to the following conditions:

- a. Each mobile storage tank must be fixed with licensed, metered pumps.
- b. Each mobile storage tank shall be assigned a separate number, and the gallonage shall be reported on a per-tank basis.
- c. Each mobile storage tank shall have printed thereon, in strokes not less than six inches in height and three-fourths inches in width, the unit number and licensee's license number.
- d. There may be a total of only nine mobile storage tanks operated under a single license. If the licensee operates more than nine such storage tanks, the licensee must obtain a separate license for each multiple of nine or fraction thereof.
- e. When a licensee changes the licensee's principal place of business, the license shall be canceled and the person must apply for a new license.
- f. All records required to be kept shall be maintained at the licensee's principal place of business.
- g. Except for the requirement of having a separate license for each location where L.P.G. is used, the licensee shall be subject to all the requirements of other licensed L.P.G. users.

**69.5(4) Exemption for emergency filling by distributors.** Upon request from a stranded motorist, an L.P.G. distributor may place up to 20 gallons of L.P.G. into the fuel supply tank of the stranded vehicle without being considered by the department in violation of Iowa Code section 452A.74(5) (acting as an L.P.G. dealer without a license); however, the distributor must remit the tax thereon on a licensed dealer form and pay the tax before the last day of the month following the month of the emergency fill.

This rule is intended to implement Iowa Code section 452A.8.  
[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.6(452A) Requirements to be licensed.** To become licensed as an L.P.G., L.N.G., or C.N.G. user or dealer, a person must file with the department a completed application form for the appropriate license. A separate license is required for each place of business or location where L.P.G., L.N.G., or C.N.G. is regularly delivered or placed into the fuel supply tank of motor vehicles. See Iowa Code section 452A.4 and 701—subrule 67.23(1) for licensing requirements.

This rule is intended to implement Iowa Code section 452A.8.  
[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.7(452A) Licensed metered pumps.** Before an L.P.G., L.N.G., or C.N.G. dealer's or user's license can be issued, all pumps designed to fuel motor vehicles at the location to be licensed must be (1) metered, (2) inspected, (3) tested for accuracy, (4) sealed, and (5) licensed by the department of agriculture and land stewardship. (See 1970 O.A.G. 2.) If there is more than one pump at a location to be licensed, each pump will be assigned a separate pump number, and the licensee shall report the gallonage each month with reference to such number.

Each special fuel L.P.G. distributor, dealer, or user may elect to measure L.P.G. for the tax purposes either temperature compensated to 60° F, or without temperature compensation. If the special fuel L.P.G. distributor, dealer or user elects to measure L.P.G. temperature compensated to 60° F for tax purposes, the L.P.G. distributor, dealer or user must use meters which are of an automatic temperature compensating type which shall compute gross gallons corrected to 60° F.

This rule is intended to implement Iowa Code section 452A.8.  
[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.8(452A) Single license for each location.** A single license is required for each separate place of business or location where L.P.G., L.N.G., or C.N.G. is delivered into the fuel supply tank of a motor vehicle. For reporting purposes (see rule 701—69.2(452A)), a licensee may file a separate return for each license; or, if arrangements have been made with the department, the licensee may file a consolidated return reporting all sales made at all locations for which a license is held. However, a consolidated return may not be used to combine dealer and user operations. All working papers used in the preparation of the information required must be available for examination by the department. All dealer or user operations at that location will be conducted under that license. A licensee may have a different type of license (dealer, user) for each separate location where L.P.G., L.N.G., or C.N.G. is dispensed. For instance,

if a licensee holds an L.P.G., L.N.G., or C.N.G. dealer's license for location A and an L.P.G., L.N.G., or C.N.G. user's license for location B, the licensee may sell fuel to others or fuel the licensee's own vehicles at location A, but may only fuel the licensee's own vehicles at location B.

This rule is intended to implement Iowa Code section 452A.8.  
[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.9(452A) Dealer's and user's license nonassignable.** An L.P.G., L.N.G., or C.N.G. dealer's license or user's license cannot be assigned. The following nonexclusive situations will be considered an assignment:

1. A change in the name under which the licensee conducts business.
2. A change in the location where the business is conducted.
3. A sale of the business (even if the new owner(s) operates under the same business name).
4. A merger or other business combination which results in a new or different entity.

This rule is intended to implement Iowa Code section 452A.8.  
[ARC 1805C, IAB 1/7/15, effective 2/11/15]

**701—69.10(452A) Separate storage—bulk sales—highway use.** If a person is operating as an L.P.G. dealer's or user's licensee and also makes bulk sales for nonhighway use, there must be separate storage for bulk sales and sales for highway. If any amount of L.P.G. in a storage facility is to be used directly from that storage for highway purposes or if the storage is connected to a device which is designed in such a way as to be able to fuel motor vehicles, all fuel dispensed from the storage shall be dispensed through licensed metered pumps. Tax will be paid on the fuel dispensed which is not exempt as evidenced by exemption certificates.

This rule is intended to implement Iowa Code section 452A.8.

**701—69.11(452A) Combined storage—bulk sales—highway sales or use.** If a person is operating as an L.P.G. dealer's or user's licensee, L.P.G. may be dispensed for bulk nontaxable sales and for taxable highway sales from the same storage if, and only if, the following requirements are complied with:

1. All pumps which are of such a design to be able to fuel motor vehicles must be licensed, sealed, metered, and inspected as provided in rule 69.5(452A).
2. All fuel passing through the pumps is taxed unless supported by exemption certificates.
3. All pumps which are not licensed, sealed, metered, and inspected must be of such a design that it is impossible to use them to place fuel into the fuel supply tank of a motor vehicle.
4. Accurate records must be kept showing all purchases of fuel and all nontaxable bulk sales of fuel.

All L.P.G. which is placed in this combined storage is presumed to be for highway use and taxable unless supported by exemption certificates (for fuel passing through the licensed pumps) or detailed records showing bulk sales for nonhighway use or to other users or dealers (for fuel passing through the nonlicensed pumps). (See 1968 O.A.G. 592.) If at any time the licensee fails to comply with the requirements of this rule, separate storage for taxable sales and nontaxable bulk sales will be required under rule 69.10(452A).

This rule is intended to implement Iowa Code section 452A.8.

**701—69.12(452A) Exemption certificates.** If L.P.G. is dispensed from metered highway storage for other than highway purposes, an exemption certificate must be completed by the seller and signed by the purchaser. The certificate is to be retained by the dealer or user. The exemption certificate must include, but not be limited to, the following information: the date, the seller's name, the seller's dealer (user) license number, the invoice number covering the fuel sold (if sold by a dealer), an indication of the use to which the fuel will be put, and the name, address, and signature of the purchaser (user). The exemption certificate will be provided by the department or a dealer or user may provide the exemption certificate provided it contains all information required by the director.

These exempt sales of L.P.G. from metered highway storage shall be limited to the following uses:

1. Placed directly into a fuel supply tank which is connected to the heating or cooling unit installed on a highway “reefer” unit, provided the fuel supply tank is not connected nor has provisions for connection directly or indirectly to the power source of the highway motor vehicle.

2. Placed directly into the fuel supply tank of a nonhighway motor vehicle.

3. L.P.G. placed into carry-out containers.

All other sales for other than highway use must be from bulk storage and not from metered highway storage. (See rule 701—68.13(452A), sales tax.)

This rule is intended to implement Iowa Code section 452A.8.

**701—69.13(452A) L.P.G. sold to the state of Iowa, its political subdivisions, contract carriers under contract with public schools to transport pupils or regional transit systems.**

**69.13(1)** If L.P.G. is sold to the state of Iowa, its agencies, a political subdivision of the state, or a regional transit system for public use, or a use specified in Iowa Code section 452A.57(11), and placed in storage, it may be sold tax-free. Fuel sold by a dealer and delivered directly into the fuel supply tank of a motor vehicle must be sold tax-paid. Since the L.P.G. delivered into storage is not subject to tax, the governmental unit or regional transit system need not be licensed as a special fuel user. However, if the L.P.G. is used by a governmental unit or regional transit system for other than “public purposes,” or a purpose specified in Iowa Code section 452A.57(11), it must obtain a user’s license and pay the tax on all highway L.P.G. used from the storage.

**69.13(2)** L.P.G. sold to a contract carrier under contract with public schools to transport pupils. When special fuel is sold directly to contract carriers who have a contract with a public school under Iowa Code section 285.5 for the transportation of pupils of an approved public or nonpublic school, the fuel shall be sold tax-paid.

If the contract carrier is licensed as an L.P.G. fuel dealer or user, the licensee may buy the fuel tax-free, but the tax must be remitted on the monthly dealer or user return.

Any contract carrier who has paid the tax is entitled to a refund. A refund requested by contract carriers will be reduced by the applicable sales tax, unless otherwise exempt. All contract carriers must apply to the department for a refund registration even if they currently hold a motor fuel tax license.

The refund will be allowed pursuant to the provisions of 701—subrule 68.8(4).

This rule is intended to implement Iowa Code sections 452A.3 and 452A.17.

**701—69.14(452A) Refunds.** Refunds of taxes paid on L.P.G. used for other than highway use are available. See rule 701—68.8(452A). The refunds are available if the tax has been paid, the L.P.G. is used other than to propel motor vehicles, the person requesting the refund has a refund permit, and the claim is filed within the appropriate time and in the appropriate manner. The income tax credit set forth in rule 701—68.12(452A) shall apply equally to special fuel.

This rule is intended to implement Iowa Code section 452A.17.

**701—69.15(452A) Notice of meter seal breakage.** Whenever a meter is required under Iowa Code chapter 452A, pursuant to the director’s power granted under Iowa Code section 452A.59, and said meter is required to be sealed by Iowa Code chapter 452A, (C.N.G. or L.P.G. dealer and user meters) the department must be notified within 24 hours of the breaking of the seal for any reason. Notice shall contain, but not be limited to, the following information:

1. The name, address, and license number of the person who controls the meter.
2. The meter number.
3. The type of fuel pumped through the meter.
4. The date of seal breakage.
5. The name and address of the person(s) responsible for the seal breakage.
6. The reason for seal breakage.
7. The meter reading before seal breakage.
8. The meter reading after the meter is resealed.
9. The signature of the person who controls the meter.

For reporting purposes, the meter shall be considered two meters, one before the seal breakage and one after, and should be reported on that basis, noting the seal breakage on the return. The meter readings of the meter before the seal breakage shall be reported by meter number as usual. The meter readings after the meter was resealed shall be reported by using the meter number plus the letter "A." The two readings must appear on the same return schedule.

This rule is intended to implement Iowa Code sections 452A.3 and 452A.8 as amended by 1999 Iowa Acts, Senate File 136, and Iowa Code sections 452A.59 and 452A.62.

**701—69.16(452A) Location of records—L.P.G. or C.N.G. users and dealers.** The records required to be prepared and kept by L.P.G. or C.N.G. dealers and users under Iowa Code section 452A.10 and 701—subrule 67.3(5) must be maintained at the location that appears on the license unless the following conditions are met:

**69.16(1)** If the licensee has more than one license, all of the records for each separate license may be kept at a central location so long as the records for each license are kept separated.

**69.16(2)** The central location where the records are kept is within the state unless:

*a.* The licensee agrees to bring the records back into the state when requested to do so by the department for purposes of audit, or

*b.* The licensee agrees to pay the cost (as defined in rule 701—67.4(452A)) of an out-of-state audit. This rule is intended to implement Iowa Code sections 452A.10 and 452A.74(2).

All rules in 701—Chapters 67 and 68 apply if not specifically stated in this chapter.

The rules in 701—Chapters 67, 68, and 69 are effective for periods beginning on or after January 1, 1996.

See 701—Chapters 63, 64 and 65 for rules in effect on or prior to December 31, 1995.

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