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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 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 or suspension 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.

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CHAPTER 96
HEMP

21—96.1(204) Definitions.

“Acceptable hemp THC concentration” means when an official laboratory tests a sample, the laboratory must report the delta-9 tetrahydrocannabinol (THC) content concentration on a dry weight basis and the measurement uncertainty. The acceptable hemp THC concentration is for the purpose of compliance when the application of the measurement uncertainty to the reported THC concentration on a dry weight basis produces a distribution or range that includes 0.3 percent or less. For example, if the reported THC concentration on a dry weight basis is 0.35 percent and the measurement uncertainty is +/- 0.06 percent, the measured THC concentration on a dry weight basis for this sample ranges from 0.29 percent to 0.41 percent. Because 0.3 percent is within the distribution or range, the sample is within the acceptable hemp THC concentration for the purpose of compliance. This definition of “acceptable hemp THC concentration” affects neither the statutory definition of hemp, 7 U.S.C. 1639o(1), in the 2018 Farm Bill nor the definition of “marihuana,” 21 U.S.C. 802(16), in the CSA.

“Applicant” means any of the following:

1. An individual with 5 percent, or more, legal or equitable interest in the hemp crop.
2. An individual applying as a member of a business entity, if that individual’s legal or equitable interest in the business entity is 5 percent or more.
3. Key participants in a corporate entity at the executive levels including chief executive officer, chief operating officer and chief financial officer.
4. If an applicant is acting on behalf of an institution governed by the state board of regents, as defined in Iowa Code section 262.7, or a community college, as defined in Iowa Code section 260C.2, “applicant” means the individual, or individuals, appointed by the president or chancellor of the institution to obtain hemp permits from the department. Other institutions of higher learning may also apply by designating an appropriate authorized representative.
5. If an applicant is acting on behalf of an association, the association shall designate an authorized representative.

“Authorized representative” means an individual designated by an applicant to act on behalf of and represent the applicant in communicating with the department for the purposes of applying for a license, submitting reports, receiving documents and information from the department, and acting as the sole primary contact pertaining to the license. An applicant may only have one authorized representative. An authorized representative shall not be a business entity.

“Business entity” means an organization created or operated by one or more individuals to carry on a trade or business.

“Cannabis” means a genus of flowering plants in the family Cannabaceae of which *Cannabis sativa* is a species, and *Cannabis indica* and *Cannabis ruderalis* are subspecies thereof. Cannabis refers to any form of the plant in which the delta-9 tetrahydrocannabinol concentration on a dry weight basis has not yet been determined.

“Certificate of analysis” means the certificate issued by the department following the official preharvest inspection, sampling and testing for total tetrahydrocannabinol (THC) concentration if the THC concentration is 0.3 percent or less by dry weight matter. The certificate of analysis shall contain the results of the department’s official laboratory test of the postdecarboxylation value concentration of the officially sampled hemp crop following the preharvest report. The certificate of analysis shall be combined with a certificate of crop inspection.

“Controlled Substances Act” or *“CSA”* means the Controlled Substances Act as codified in 21 U.S.C. 801, et seq.

“Crop site” or *“site”* means a single contiguous parcel of land suitable for the planting, growing, or harvesting of hemp, if the parcel does not exceed 40 acres. All the area within the contiguous parcel is part of the crop site. Unplanted areas, including spacing between planted rows, are part of the crop site for purposes of determining the size of a parcel. The crop site shall not be a dwelling.

“*Cultivar*” means a group of cultivated plants that are not necessarily true to type, or plants whose seed will yield the same type of plant as the original plant. A cultivar may originate as a mutation or may be a hybrid of two plants. To further develop into a variety, or propagate true-to-type clones, cultivars must be propagated vegetatively through cuttings, grafting, and even tissue culture.

“*Decarboxylated*” means the completion of the chemical reaction that converts THC-acid (THCA) into delta-9-THC, the intoxicating component of cannabis. The decarboxylated value is also calculated using a conversion formula that sums up delta-9-THC and 87.7 percent of THCA.

“*Decarboxylation*” means the removal or elimination of a carboxyl group from a molecule or organic compound.

“*Department*” means the Iowa department of agriculture and land stewardship.

“*Destruction*” means the procedure to render unusable by burning, incorporating with other materials, or other methods approved by the department.

“*Destruction report*” means the report and notice that shall be submitted to the department on the required departmental form, no more than 48 hours after the crop has been destroyed, as ordered by the department.

“*Drug felony conviction report*” means a mandatory report submitted within 14 days of the conviction to the department on the required departmental form by any authorized representative or applicant who is convicted of a disqualifying felony offense.

“*Dry weight basis*” means the ratio of the amount of dry solid in a sample after drying to the total mass of the sample before drying, including the moisture in a sample. Dry weight basis is the percentage of a chemical in a substance after removing the moisture from the substance. Percentage of THC on a dry weight basis means the percentage of THC, by weight, in a cannabis item (plant, extract, or other derivative), after excluding moisture from the item.

“*Dwelling*” means a residence and all permanent or temporary structures attached to the residence.

“*Entity*” means a corporation, joint-stock company, association, limited partnership, limited liability partnership, limited liability company, irrevocable trust, estate, charitable organization, or other similar organization participating in the production of hemp, including but not limited to as a partner, joint venture, or other relationship.

“*Farm Service Agency*” or “*FSA*” means the Farm Service Agency of the United States Department of Agriculture.

“*Geospatial location*” means a location designated through a global system of navigational satellites used to determine the precise ground position of a place or object.

“*Hemp*” means:

1. The plant *Cannabis sativa* L. and any part of that plant, including the seeds thereof, and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a delta-9 tetrahydrocannabinol concentration of 0.3 percent or less on a dry weight basis when tested using postdecarboxylation or other similarly reliable methods.

2. A plant of the genus *Cannabis* other than *Cannabis sativa* L., with a delta-9 tetrahydrocannabinol concentration of 0.3 percent or less on a dry weight basis when tested using postdecarboxylation or other similarly reliable methods, but only to the extent allowed by the department in accordance with applicable federal law, including the federal hemp law.

“*Hemp bill of lading*” means a document of title evidencing the receipt of hemp for shipment issued by an individual engaged in the business of directly or indirectly transporting or forwarding hemp. The term does not include a warehouse receipt. The term does not include hemp transported within the state of Iowa by a person for that person’s sole use. A hemp bill of lading shall include the following:

1. The name and address of the owner of the hemp;
2. The point of origin;
3. The point of delivery, including name and address;
4. The kind and quantity of packages or, if in bulk, the total quantity of hemp in the shipment; and
5. The date of shipment.

“*High-performance liquid chromatography*” or “*HPLC*” means a type of chromatography technique in analytical chemistry used to separate, identify, and quantify each component in a mixture.

HPLC relies on pumps to pass a pressurized liquid solvent containing the sample mixture through a column filled with a solid adsorbent material to separate and analyze compounds.

“Individual” means a single human being. An entity is not an individual.

“Indoor crop site” means:

1. A structure covered with transparent material, such as glass or polyurethane, which is specifically designed, constructed and used for the culture and propagation of hemp. Common industry terms for indoor crop sites include, but are not limited to, greenhouse, glasshouse, and hothouse; or
2. A structure, or a room within a structure, used for the culture and propagation of hemp.

“License” means a license granted by the department to grow hemp in Iowa.

“License application” means the department’s form submitted to obtain a license to grow hemp in Iowa.

“Lot” means a contiguous area in a field, greenhouse, or indoor crop site containing the same variety, cultivar, or strain of cannabis throughout. No plant within a lot shall be planted more than 14 days after the initial plant or seed was planted. In addition, “lot” is a common term in agriculture that refers to the batch or contiguous, homogeneous whole of a product being sold to a single buyer at a single time. For the purpose of this chapter, “lot” is to be defined by the producer in terms of farm location, field acreage, variety, cultivar or strain and to be reported as such to the FSA.

“Map” means a diagram depicting all borders of the crop site including the nearest roads to aid in orientation, the cardinal direction north, and the boundaries of the legally described parcel in which the crop site is located. A map designating an outdoor crop site shall clearly indicate the names, or lot numbers, of all lots and planting locations. If multiple varieties, cultivars, or strains are planted, or if the crop site shall be subdivided into separate lots for the official laboratory test, the map shall indicate the lots and sub-lots with names of the varieties, cultivars, or strains.

“Measurement uncertainty” or *“MU”* means the parameter, associated with the result of a measurement, that characterizes the dispersion of the values that could be reasonably attributed to the particular quantity subject to measurement.

“Official laboratory test” means a test of postdecarboxylation value concentration performed by the department. The laboratory quantitative determination of the THC concentration shall use postdecarboxylation and be measured using gas chromatography with flame ionization detector (GS-FID), high performance liquid chromatography (HPLC) or another acceptable method as determined by the department.

“Official sample” means the preharvest hemp sample collected by the department, in accordance with department policy, which is used to assess the THC concentration of a single lot of hemp.

“Order of destruction” means the order furnished to the licensee by the department, in consultation with the department of public safety, ordering the destruction of cannabis that exceeds the acceptable hemp THC concentration.

“Outdoor crop site” means any crop site that is not an indoor crop site.

“Planting report” means the report and notice submitted to the department on the required departmental planting report form. Planting reports are required for both indoor and outdoor hemp crops.

“Postdecarboxylation value,” in the context of testing methodologies for THC concentration in hemp, means a value determined after the process of decarboxylation that determines the total potential delta-9 tetrahydrocannabinol (THC) content derived from the sum of the THC and delta-9-tetrahydrocannabinolic acid (THCA) content and reported on a dry weight basis. The postdecarboxylation value of THC can be calculated by using a chromatographic technique using heat, gas chromatography, through which THCA is converted from its acid form to its neutral form, THC. Thus, this test calculates the total potential THC in a given sample. The postdecarboxylation value of THC can also be calculated by using a high-performance liquid chromatograph technique, which keeps the THCA intact and requires a conversion calculation of that THCA to calculate total potential THC in a given sample.

“*Postharvest report*” means the report and notice that the licensee shall deliver to the department on the required departmental postharvest report form, no more than 30 days after the harvest of a lot is complete.

“*Preharvest inspection*” means the inspection to collect one or more official samples for official laboratory testing.

“*Preharvest report*” means the report and notice that the licensee shall deliver to the department on the required departmental preharvest form in order to request a preharvest inspection. The licensee shall submit the preharvest report no less than 30 days prior to the expected harvest date of any hemp crop.

“*Reverse distributor*” means a person who is registered with Drug Enforcement Administration (DEA) in accordance with 21 CFR 1317.15 to dispose of marijuana under the Controlled Substances Act.

“*Strain*” means variations of a cultivar, generally from breeding techniques or genetic mutations.

“*Sub-lot*” means an area divided from a larger lot. A lot may be divided into multiple sub-lots.

“*Temporary harvest and transportation permit*” means a temporary and limited permit issued by the department when the official sample is taken, allowing the harvest and transportation of the officially tested crop prior to the completion of official laboratory sampling.

“*THC*” means total tetrahydrocannabinol as determined by an official laboratory test postdecarboxylation.

“*Variety*” means a plant grouping within a single botanical taxon of the lowest known rank that, without regard to whether the conditions for plant variety protection are fully met, can be defined by the expression of the characteristics resulting from a given genotype or combination of genotypes, distinguished from any other plant grouping by the expression of at least one characteristic and considered as a unit with regard to the suitability of the plant grouping for being propagated unchanged. A variety may be represented by seed, transplants, plants, tubers, tissue culture plantlets, and other matter.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.2(204) Licensing. A license to grow hemp shall be obtained from the department. In order to obtain and maintain a license, an applicant shall submit a license application, receive approval from the department, and comply with the standards contained in Iowa Code chapter 204 and these rules.

96.2(1) A license is nontransferable unless approved by the department.

96.2(2) In 2020, the license application for an outdoor crop site shall be submitted to the department on or before May 15. Indoor crop site applications may be submitted at any time.

96.2(3) In 2021 and thereafter, the license application for an outdoor crop site shall be submitted to the department on or before April 15. Indoor crop site license applications may be submitted at any time.

96.2(4) Failure to include all applicants shall preclude the license application from consideration.

96.2(5) Applicants shall submit an application form. A complete application form shall include, at a minimum, the following:

- a. The authorized representative’s full name and mailing address.
- b. A legal description and map of each crop site where the applicant proposes to produce hemp.
- c. The geospatial location of the center of the crop site.
- d. The number of crop acres intended for hemp production. For fractions of acres, round to the next whole number.
- e. The name of the hemp varieties, cultivars or strains proposed to be grown by the applicant.
- f. The intended hemp crop to be grown by the applicant; this includes grain, seed, fiber, cannabidiol (CBD), clones, cuttings, plantlets, or other identifying information.
- g. The type of crop site (indoor or outdoor).
- h. All parties with an ownership interest in the crop site or hemp crop. If the crop site is leased, the name and contact information of all lessors and lessees with any interest in the crop site or hemp crop shall be provided.

i. The destruction method the applicant intends to use to destroy the cannabis if the crop fails to meet the acceptable hemp THC concentration. The destruction method must be approved by the department prior to actual destruction.

96.2(6) The authorized representative and all applicants shall submit official fingerprints to the department as a part of the application process. All national criminal history record check fees shall be paid to the department.

96.2(7) All license applications shall be submitted to the department electronically via the online license application portal. An authorized representative may request a waiver from the department to submit an application through an alternative format.

96.2(8) Real-time information, including but not limited to the status and number of the producer's license, shall be accessible via the department's online license application portal. Information submitted to the department via the online license application portal shall be collected, maintained, and reported to the USDA as required by the USDA in 7 CFR Part 990, Subpart C.

96.2(9) A license expires on December 31 of the year the license is issued.

96.2(10) An applicant with a state or federal felony conviction relating to a controlled substance is subject to a ten-year ineligibility from the date of the conviction.

96.2(11) Any applicant who materially falsifies any information contained in an application shall be ineligible for a license.

96.2(12) The department may implement additional reasonable licensing requirements at its discretion.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.3(204) National criminal history record check.

96.3(1) Disqualifying offenses.

a. An applicant shall not be convicted of, or plead guilty to, a disqualifying felony offense. All applicants shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history record check.

b. The department or the department of public safety may request additional information to complete a background investigation and national criminal history background check. An applicant or authorized representative shall respond within 30 days to any request for additional information. Failure to timely respond shall result in a denial of the license application.

c. The department may deny any application for good cause.

96.3(2) An applicant and authorized representative shall provide fingerprints to the department. The department shall provide the fingerprints to the department of public safety for submission through the state criminal history repository to the federal bureau of investigation.

96.3(3) The applicant shall pay the actual cost of conducting any national criminal history record check to the department.

96.3(4) The results of a national criminal history check may be valid for three consecutive license years unless a drug-related felony conviction occurs after the issuance of the national criminal history record check results.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.4(204) Licensee reports.

96.4(1) *Planting report.*

a. Outdoor planting report. Within 14 days after planting an outdoor hemp crop, the authorized representative shall submit a planting report to the department. The planting report does not constitute the required preharvest report. The planting report shall be on a form prepared and distributed by the department that shall include, but is not limited to:

- (1) The authorized representative's full name and contact information.
- (2) The license number.
- (3) The anticipated harvest date.
- (4) An updated detailed map depicting any changes.

b. Indoor planting report. On the first day of the month following any planting activity in the immediately preceding month, the authorized representative shall submit a planting report. The planting report does not constitute the required preharvest report. The planting report shall be on a departmental form prepared and distributed by the department. The planting report form shall include, at a minimum, the following:

- (1) The authorized representative's full name and contact information.
- (2) The license number.
- (3) The anticipated harvest date.

96.4(2) Preharvest report. The authorized representative shall submit a preharvest report to the department no less than 30 days prior to the expected harvest date of the hemp crop produced at the licensee's crop site. The licensee shall be entirely responsible for determining the expected harvest date for the hemp crop. The preharvest report shall be on a departmental form prepared and distributed by the department. The preharvest report form shall include, at a minimum, the following:

- a.* The authorized representative's full name and contact information.
- b.* The license number.
- c.* The anticipated date range for initiating and completing harvest, recorded by lot.
- d.* A map of the outdoor crop site. If more than one harvest date is being reported for the lots within the crop site, the map shall designate the locations of the lots, and the intended harvest dates, which are to be harvested under the preharvest report.

96.4(3) Postharvest report. The licensee shall deliver the postharvest report to the department no less than 14 days after the harvest of a lot is complete. If any lots within a crop site are harvested at different times, each harvest date shall be independently recorded by lot. The postharvest report shall be on a departmental form prepared and distributed by the department. The postharvest report form shall include, at a minimum, the following:

- a.* The authorized representative's full name and contact information.
- b.* The license number.
- c.* The harvest date(s).
- d.* The independent harvest date of each lot.

96.4(4) Destruction report. The licensee shall deliver a destruction report no more than 48 hours after crop destruction, or as ordered by the department. The destruction report shall be on a form prepared and distributed by the department. The destruction report shall include, but is not limited to:

- a.* The authorized representative's full name and contact information.
- b.* The license number.
- c.* The destruction date(s).
- d.* The method of destruction.
- e.* The independent destruction date of each lot.

96.4(5) Drug felony conviction report. Any authorized representative or applicant who is convicted of, or pleads guilty to, a disqualifying felony offense must report the disqualifying offense to the department and any co-licensees within 14 days of the conviction. The offender shall immediately forfeit the license. In the case of multiple licensees holding a single license, the offender's interest in the license shall be immediately terminated. Failure to report the disqualifying offense may result in an order of destruction. The drug felony conviction report shall be on a form prepared and distributed by the department that shall include, but is not limited to:

- a.* The license number(s).
- b.* The name and contact information for the individual reporting the individual's conviction.
- c.* The date of conviction.
- d.* An acknowledgment that all co-licensees have been informed of the disqualifying offense, if applicable, and the co-licensees have assumed full responsibility for the hemp crop.

96.4(6) Hemp acreage report to the FSA. Within 30 days after the completion of planting of an outdoor crop site, or within 30 days after the first planting of hemp in the calendar year in an indoor crop site, the authorized representative shall report the hemp acreage to the FSA. At a minimum, the following information shall be reported:

- a. Street address and geospatial location for each crop site.
- b. Acreage for each crop site.
- c. The license number.

96.4(7) Voluntary destruction report. If a licensee chooses to destroy a lot prior to harvest, the authorized representative shall notify the department of the licensee’s intent to destroy the crop within seven days prior to the destruction. The hemp crop shall not be destroyed unless the department or local law enforcement either is present during the destruction or has authorized destruction to occur unwitnessed. The voluntary destruction report shall be on a form prepared and distributed by the department that shall include, but is not limited to:

- a. The authorized representative’s full name and contact information.
- b. The license number.
- c. The date(s) and method of destruction for each lot.
- d. The identification number or name of the lot(s).
- e. The reason for destruction.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.5(204) Fees. The department shall impose, assess, and collect fees, which shall be paid by a licensee. All fees shall be collected by the department before the department takes any action for which the fee is applicable. All fees are nonrefundable.

96.5(1) The license fee shall be paid prior to acceptance of a license application. License fees shall be based on the number of acres in a crop site, as follows:

TABLE 1
LICENSE FEES PER CROP SITE

Acres	Fee	
0 - 5	\$500 + \$5 per acre	Paid at application
5.1 - 10	\$750 + \$5 per acre	
10.1 - 40	\$1,000 + \$5 per acre	

96.5(2) A primary base fee shall be paid prior to acceptance of a license application. Payment of a primary base fee shall secure the preharvest inspection. The preharvest inspection shall include the collection of an official sample and an official test of that sample. Prior to, or during, the preharvest inspection, a licensee may request official sampling of additional lots and sub-lots. A primary supplemental fee shall be charged for each additional official sample and official test. All primary supplemental fees shall be paid prior to performance of any official test, as follows:

TABLE 2
PRIMARY FEES

Primary Base Fee	Primary Supplemental Fee
\$1,000 per sample	\$500 per sample
Paid at application	Paid prior to official sampling

96.5(3) A licensee may request one or more secondary preharvest inspections. Payment of a secondary base fee shall secure a secondary preharvest inspection. The secondary preharvest inspection shall include the collection of an official sample and an official test of that sample. Prior to, or during, any sampling, a licensee may request official sampling of additional lots and sub-lots. A secondary supplemental fee shall be charged for each additional official sample and official test. All secondary supplemental fees shall be paid prior to performance of any official test, as follows:

TABLE 3
SECONDARY FEES

Secondary Base Fee	Secondary Supplemental Fee
\$1,000 per sample	\$500 per sample
Paid prior to official sampling	Paid prior to official sampling

96.5(4) A licensee may request a single retest of a sample collected for a lot or sub-lot if the licensee believes the original official laboratory test result was in error. The licensee may not request the collection of a new sample. The licensee requesting the retest of the sample shall pay the retest fee prior to performance of official retest. The retest fee shall be \$500.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.6(204) Annual review of licensees to ensure licensure compliance.

96.6(1) The authorized representative shall certify the licensee has operated and will continue to operate in accordance with Iowa Code chapter 204 by executing a certification of compliance as part of the harvest report, by answering the following questions:

- a. Have you operated in accordance with all license requirements?
- b. Has any of the following information changed?

(1) The authorized representative and all individual applicants' full names, titles, residential addresses, phone numbers, or email addresses.

- (2) Key participant title in the business entity.
- (3) The structure of or ownership interests in the business entity.

c. Were the hemp acres at the crop site reported to the FSA?

d. Have any hemp plants been harvested or removed from the crop site prior to official sampling and official testing?

96.6(2) Crop sites that do not harvest hemp and solely propagate cuttings and clones shall be inspected at least annually.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.7(204) Sampling procedures for official testing of hemp for THC content.

96.7(1) The licensee shall submit a preharvest report to the department at least 30 days prior to the anticipated harvest date.

96.7(2) Official samples for official testing shall be collected by the department or a third-party sampler designated by the department.

96.7(3) The authorized representative, or licensee, shall be present at any preharvest inspection and official sampling of the crop site.

96.7(4) The department inspector will verify the geospatial location coordinates submitted to the department.

96.7(5) The licensee must allow complete and unrestricted access to the crop site. If the licensee fails to provide unrestricted access, an official sample will not be collected.

a. If cannabis plants are observed outside of the crop site boundaries, the department shall notify law enforcement.

b. If the department inspector suspects that the licensee harvested hemp plants prior to official sampling, the department inspector will immediately cease official sampling and notify the Iowa hemp program administrator. The Iowa hemp program administrator shall determine how to proceed with an investigation, seeking law enforcement assistance as necessary.

96.7(6) A separate official sample shall be taken for each lot and sub-lot. In accordance with the fee schedule established by the department, a supplemental fee shall be charged for every sample after one sample.

96.7(7) If the licensee chooses to have official samples taken from sub-lots within a lot, the boundary between sub-lots shall be discernable. In an outdoor crop site, the minimum row space between lots and sub-lots shall be twice the normal row spacing, but no less than 36 inches.

96.7(8) The department inspector shall take a representative official sample of each lot and sub-lot, walking at right angles to the rows if possible. The department inspector may take more cuttings than the minimum listed in Table 4 if necessary to obtain an adequate official sample.

96.7(9) The official sample collected by the department shall consist of approximately 2-inch cuttings of flowering material, meaning inflorescences (the flower or bud of plant), from the top one-third of the plant, based on the following table:

TABLE 4
NUMBER OF PLANTS SAMPLED, BASED ON LOT AND SUB-LOT ACREAGE SIZE

Number of acres	Number of plants sampled	Number of acres	Number of plants sampled	Number of acres	Number of plants sampled	Number of acres	Number of plants sampled
1	10	11	11	21	20	31	29
2	10	12	12	22	21	32	29
3	10	13	13	23	22	33	30
4	10	14	14	24	23	34	31
5	10	15	15	25	24	35	32
6	10	16	16	26	24	36	33
7	10	17	17	27	25	37	34
8	10	18	18	28	26	38	34
9	10	19	18	29	27	39	35
10	10	20	19	30	28	40	36

96.7(10) The plants and plant material selected for official sampling shall be determined solely by the department.

96.7(11) All samples shall become the property of the department and are nonreturnable.

96.7(12) The department inspector will place the official composite representative sample in a properly labeled paper bag. The labeled bag will be sealed with security tape, and the following information shall be placed on the paper bag:

- a. License number;
- b. Name and contact information of the sampling agent;
- c. Name and contact information of the licensee;
- d. Date sample was taken;
- e. Sample identification number for the lot or sub-lot;
- f. Parcel identification number from the FSA; and
- g. Any other information that may be required by the department.

96.7(13) The official sample and sampling report shall be hand-delivered or placed in a box, sealed with security tape, and overnight shipped to the department laboratory.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.8(204) Approved testing methods of hemp for THC content.

96.8(1) The department laboratory shall be the only official laboratory for analyzing official samples from licensed crop sites in Iowa.

96.8(2) An appropriate chain of custody will be maintained at all times, and the information from the sampling form will be input into the department laboratory information management system.

96.8(3) The official samples will be dried, the stem and seed will be separated from floral material and discarded, and the floral material will be ground.

96.8(4) The ground floral material will be tested for THC content.

- a. Any remaining floral material will be retained by the department for three months.
- b. If a licensee requests a single retest of a lot or sub-lot, the department shall retest any remaining floral material.

96.8(5) The THC concentration will be determined by gas-liquid chromatography (GC) or other acceptable method as determined by the department.

96.8(6) The department will utilize MU in determining acceptable hemp THC concentration.

96.8(7) If the official laboratory test results in the acceptable hemp THC concentration, the department shall issue a certificate of analysis, as provided in Iowa Code section 204.8, and immediately send the certificate of analysis to the authorized representative.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.9(204) Harvesting timing.

96.9(1) A licensee shall not harvest any portion of a hemp crop unless the department has officially sampled the lot to be harvested.

96.9(2) The licensee may begin harvesting the corresponding lots and sub-lots upon receiving a temporary harvest and transportation permit. The temporary harvest and transportation permit will expire once a certificate of analysis, or destruction order, is issued.

a. Prior to receiving the temporary harvest and transportation permit, the licensee shall designate a storage site for the hemp crop. The licensee shall ensure that the department has unrestricted access to the crop at all times, including, if necessary, to fulfill an order of destruction. The harvested crop shall remain at the designated storage site until a certificate of analysis, or order of destruction, is issued.

b. The designated storage site must be within the state of Iowa.

c. All harvested lots and sub-lots shall be stored in a manner that preserves identity, regardless of the form, condition, or location of the crop. There shall be no commingling of separate harvested hemp lots.

96.9(3) Until the certificate of analysis is received, ownership of the hemp crop shall not change.

a. The licensee shall harvest an officially sampled hemp lot no later than 15 days after the lot was officially sampled. If the licensee has not completed harvest within 15 days and still desires to harvest any remaining crop, the licensee shall contact the department and request supplemental official sampling and official laboratory tests.

b. The day the crop site is officially sampled shall be considered day 0. The next day is considered day 1 after sampling, and so on, until day 15.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.10(204) Order of destruction.

96.10(1) If the official laboratory test does not result in an acceptable hemp THC concentration, the department shall order the destruction of the hemp crop to occur as ordered by the department.

96.10(2) If any official test exceeds acceptable hemp THC concentration, the department shall notify the department of public safety, local law enforcement, and the United States Department of Agriculture (USDA) hemp administrator.

96.10(3) If any official test exceeds 0.5 percent THC on a dry weight basis, the department shall notify the department of public safety, local law enforcement, the USDA hemp administrator, and the United States attorney general.

96.10(4) If any official test result exceeds 2.0 percent THC on a dry weight basis, the department shall notify the department of public safety, local law enforcement, the USDA hemp administrator, the United States attorney general, the county attorney, and the Iowa attorney general.

96.10(5) Failure to harvest any portion of a hemp lot 15 or more days after the lot was officially sampled may result in the issuance of an order of destruction.

96.10(6) The department may require the licensee to utilize a reverse distributor for destruction.

96.10(7) The department shall notify the USDA hemp administrator when the destruction is complete.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.11(204) Negligent violations.

96.11(1) Negligent violations shall include but are not limited to:

a. The production of hemp that exceeds the acceptable hemp THC concentration but is less than 0.5 percent THC on a dry weight basis.

b. Failure to submit required reports within mandated submission deadlines.

c. Failure to provide a legal description of the land on which the licensee produces hemp.

The department may determine additional negligent violations as needed.

96.11(2) All licensees associated with the license shall receive the negligent violation.

96.11(3) The failure to obtain a license is not a negligent violation.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.12(204) Negligent violation program.

96.12(1) The department shall require the completion of a corrective action plan for negligent violations. A licensee shall submit a corrective action plan to the department for consideration and approval. A corrective action plan shall consist of the following:

a. A reasonable time period, approved by the department, for correcting a negligent violation. Failure to correct a negligent violation within the reasonable time period shall be considered an additional negligent violation.

b. A proposed schedule for the licensee to submit periodic compliance reports to the department, when applicable. The duration for the ongoing compliance reports shall not be less than two calendar years following the violation.

c. Any other requirement established by the department.

96.12(2) The department may conduct any inspection, review, or other action to determine if the corrective action plan has been implemented as approved by the department.

96.12(3) The department shall issue a certificate of completion to the licensee upon the successful completion of the corrective action plan.

96.12(4) A licensee who is participating in, or who successfully completes, the corrective action plan shall not be subject to any criminal enforcement action pertaining to the negligent violations by the federal, state, tribal, or local government.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

21—96.13(204) State plan. The department has adopted a state plan, as prescribed by the United States Department of Agriculture, in order to assume primary regulatory authority over the production of hemp in Iowa.

[ARC 4989C, IAB 3/11/20, effective 2/24/20]

These rules are intended to implement Iowa Code section 204.3.

[Filed Emergency ARC 4842C, IAB 1/1/20, effective 12/11/19]

[Filed Emergency ARC 4989C, IAB 3/11/20, effective 2/24/20]

CHAPTER 22
NOTIFICATION AND FEES

61—22.1(537) Purpose. The purpose of these rules is to implement the notification and fees section of the Iowa consumer credit code, Iowa Code sections 537.6201 to 537.6203. The fees collected are used for the administration of the credit code.

61—22.2(537) Applicability.

22.2(1) Coverage. The following persons are included within the scope of the notification and fees sections:

a. "Creditors" who are engaged in consumer credit transactions and acts, practices or conduct involving consumer credit transactions to which this chapter applies pursuant to Iowa Code section 537.1201. The term "creditors" includes creditors engaged in consumer credit sales, consumer loans, refinancing or consolidation of sales or loans, consumer leases, or consumer rental purchase agreements, as these terms are defined in Iowa Code sections 537.1301 and 537.3604(8).

b. "Debt collectors," as defined in Iowa Code section 537.7102(5), whose acts, practices or conduct is governed by Iowa Code chapter 537 pursuant to 537.1201. Debt collectors whose total debt collected in the preceding calendar year is less than \$25,000, and in the current calendar year less than \$25,000, are exempt from the notification and fees section of the consumer credit code. The term "debt collectors" is not limited to creditors or debt collectors collecting debts arising from consumer credit transactions, but also includes the collection of debts as that term is defined in Iowa Code section 537.7102(3).

22.2(2) Exempt parties. Creditors and debt collectors who are licensed, certified, or otherwise authorized to engage in business by Iowa Code chapter 524, 533, 534, 536, or 536A are exempt from the notification and fees section of the Iowa consumer credit code. Therefore, for purposes of this chapter, the terms "creditors" and "debt collectors" do not include parties exempted by Iowa Code section 537.6201 and this subrule.

61—22.3(537) Definitions.

"Administrator" is defined in Iowa Code section 537.6103.

"Assignee" means a person who purchases consumer credit sales contracts, consumer leases, or consumer loans from a seller, lessor or lender.

"Consumer credit sale" is defined in Iowa Code section 537.1301(12).

"Consumer credit transaction" is defined in Iowa Code section 537.1301(11).

"Consumer lease" is defined in Iowa Code section 537.1301(13).

"Consumer loan" is defined in Iowa Code section 537.1301(14).

"Consumer rental purchase agreement" is defined in Iowa Code section 537.3604(8).

"Creditor" is defined in Iowa Code section 537.1301(17).

"Debt" is defined in Iowa Code section 537.7102(3).

"Debt collection" is defined in Iowa Code section 537.7102(4).

"Debt collector" is defined in Iowa Code section 537.7102(5).

"Lender" is defined in Iowa Code section 537.1301(23).

"Lessor" means a person who issues a consumer lease.

"Seller" is defined in Iowa Code section 537.1301(39).

61—22.4(537) Notification.

22.4(1) Coverage. All creditors and debt collectors shall file a notification statement with the administrator. The statement should be filed at the following address: Administrator of the Iowa Consumer Credit Code, Consumer Protection Division, Department of Justice, Hoover State Office Building, Des Moines, Iowa 50319.

22.4(2) Filing date. Persons required to file a notification statement shall file within 30 days after commencing business in this state, or within 30 days after April 24, 1991, whichever is applicable, and

thereafter, on or before January 31 of each year. Information filed should be based on the preceding calendar year.

22.4(3) Contents of notification statement. The notification statement shall contain all of the information required by Iowa Code section 537.6202.

22.4(4) Updating. The notification statement shall be updated annually on or before January 31 of each year. Should information provided in the statement become inaccurate after filing, no further notification is required until the following January 31.

61—22.5(537) Fees. All persons subject to the notification and fees section of the Iowa consumer credit code must pay the following fees:

22.5(1) Annual fees. All creditors and debt collectors, including assignees, who are required to file notification statements shall pay to the administrator an annual fee of \$50. This fee shall be paid with the filing of the first notification and on or before January 31 of each succeeding year.

22.5(2) Volume fees.

a. Sellers, lessors and lenders.

(1) Amount of fee. Sellers, lessors and lenders must also pay an additional fee at the time of filing of \$10 for each \$100,000, or part thereof exceeding \$10,000, of the average unpaid balances of obligations arising from consumer credit transactions entered into or modified by the person in this state and held on the last day of each calendar month during the preceding calendar year and held by the seller, lessor or lender. Lessors must pay an identical amount on the unpaid scheduled periodic payments for consumer leases. Sellers, lessors and lenders must also pay this amount on unpaid balances held by an immediate or remote assignee who has not filed notification. The unpaid balances of assigned obligations held by an assignee who has not filed a notification statement are presumed to be the unpaid balances of the assigned obligations at the time of their assignment by the seller, lessor or lender. Sellers, lessors and lenders who assign obligations to a party exempt under subrule 22.2(2) need not pay volume fees on these obligations after they have been assigned.

(2) Method of calculation. The average unpaid balance arising from consumer credit transactions for the preceding calendar year is determined by totaling the unpaid consumer credit balances held at the end of each month, including unpaid scheduled periodic payments under consumer leases. Included in this amount are consumer credit transactions assigned to assignees who have not filed notification statements. This total is then divided by 12. The volume fee is determined by taking this amount and assessing \$10 on each \$100,000 of outstanding credit. Volume amounts exceeding \$100,000 by more than \$10,000 are counted as an additional \$100,000 for the purpose of assessing the volume fee (e.g., an average unpaid balance of \$511,000 would generate a \$60 volume fee: \$10 for each \$100,000 in volume, and \$10 for the additional \$11,000).

b. Assignees.

(1) Amount of fee. Assignees must also pay an additional fee at the time of filing of \$10 for each \$100,000, or part thereof exceeding \$10,000, of the average unpaid balances of obligations arising from consumer credit transactions entered into or modified in this state, taken by the person by assignment and held by the person on the last day of each calendar month during the preceding calendar year. Assignees must pay an identical amount on assignments of unpaid scheduled periodic payments of consumer leases.

(2) Method of calculation. The average unpaid balances arising from consumer credit transactions for the preceding calendar year is determined by totaling the unpaid balances at the end of each month, including unpaid scheduled periodic payments under consumer leases. This amount is then divided by 12. The volume fee is determined by taking this total and assessing \$10 on each \$100,000 of outstanding credit. Volume amounts exceeding \$100,000 by more than \$10,000 are counted as an additional \$100,000 for the purpose of assessing the volume fee.

c. Debt collectors. Debt collectors subject to the notification and fees section of the credit code who are not engaged in consumer credit transactions are exempt from the assessment of volume fees.

22.5(3) Method of payment. The annual fee and applicable volume fees are to be included with the notification statement and filed within 30 days after April 24, 1991, and thereafter on or before January 31 of each year. The fees should be made payable to Iowa Consumer Credit Administration Fund.

Creditors shall pay volume fees in the first year of administration of the notification and fees section. These fees shall be calculated on the average unpaid consumer balances for the 1990 calendar year. Creditors may request consideration of alternative methods of calculating volume fees for 1990 if they can demonstrate that their records are not kept in a manner permitting them to calculate the fees as required, and that the alternative method proposed would approximate or exceed the volume fees that would be paid according to the statutory calculation method. All creditors shall comply with the statutory volume fee calculation method beginning with the 1992 notification and fee period.
[ARC 4969C, IAB 3/11/20, effective 4/15/20]

61—22.6(537) Sanctions. The following sanctions are available to the administrator for use against creditors and debt collectors who are not in compliance with the notification and fees section. These sanctions are cumulative.

22.6(1) *Late charge.* The administrator may collect a late charge of \$75 from any party subject to Iowa Code sections 537.6201 to 537.6203 who has failed to pay the required fees in full within 30 days after their due date.

22.6(2) *Civil action.* The administrator may bring a civil action against parties subject to Iowa Code sections 537.6201 to 537.6203 who have failed to file a notification statement or to timely pay their fees in full pursuant to Iowa Code section 537.6113(3). The administrator may request the fees owed, interest on those fees at a rate of 7 percent per annum, the reasonable costs of bringing the action and a civil penalty.

[ARC 3629C, IAB 2/14/18, effective 3/21/18]

These rules are intended to implement Iowa Code sections 537.6201 to 537.6203 and 537.6117.

[Filed 3/1/91, Notice 11/14/90—published 3/20/91, effective 4/24/91]

[Filed ARC 3629C (Notice ARC 3308C, IAB 9/13/17), IAB 2/14/18, effective 3/21/18]

[Filed ARC 4969C (Notice ARC 4862C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

CHAPTER 9
DISCRIMINATION IN HOUSING

161—9.1(216) Construction of chapter.

9.1(1) *Limitation of chapter.* All the rules contained herein apply only to:

- a. Complaints which allege a violation of the prohibitions contained in Iowa Code section 216.8 or 216.8A;
- b. Complaints which allege a violation of Iowa Code section 216.11 or 216.11A arising out of alleged violations of the prohibitions contained in Iowa Code section 216.8 or 216.8A; and the interpretation of the provisions of the Iowa Code which relate to such complaints or to unfair or discriminatory practices in the area of housing.

9.1(2) *Conflicting rules.* Where a provision of this chapter applies under the terms of subrule 9.1(1) and that provision conflicts with a rule of the commission not contained within Chapter 9, then the provision contained within Chapter 9 shall prevail.

161—9.2(216) Definitions. As used in this chapter, the following definitions shall apply:

“Party” means any complainants and respondents involved in the complaint of discrimination under investigation.

“Presiding officer for discovery” means an administrative law judge employed by the department of inspections and appeals and assigned to render decisions regarding discovery disputes arising in the course of civil rights commission investigations.

161—9.3(216) Interpretation of various housing provisions.

“Aggrieved person.” As used in the Iowa civil rights Act provisions relating to discrimination in housing, the term “aggrieved person” includes any person who claims to have been injured by a discriminatory housing practice, or any person who believes that that person will be injured by a discriminatory housing practice that is about to occur.

“Discriminatory housing or real estate practice.” A person who violates the prohibitions contained in Iowa Code section 216.8 or 216.8A commits an “unfair or discriminatory practice” in the area of housing or real estate. A person who commits a violation of Iowa Code section 216.11 or 216.11A arising out of alleged violations of the prohibitions contained in Iowa Code section 216.8 or 216.8A commits an “unfair or discriminatory practice” in the area of housing or real estate.

“Dwelling.” As used in Iowa Code chapter 216, the term “dwelling” means any building, structure, or portion thereof which is occupied as, or designed or intended for occupancy as, a residence by one or more families, or any vacant land which is offered for sale or lease for the construction or location thereon of any such building, structure or portion thereof.

“Exceptions.” The exceptions found in Iowa Code sections 216.12(2), 216.12(3), and 216.12(5) do not apply to Iowa Code section 216.8(3) relating to advertising.

“Handicap.” As used in Iowa Code section 216.2(5), the term “handicap” with respect to a person means:

1. A physical or mental impairment which substantially limits one or more of such person’s major life activities,
2. A record of having such an impairment, or
3. Being regarded as having such an impairment.

Such term does not include current, illegal use of or addiction to a controlled substance (as defined in Section 102 of the Controlled Substances Act, 21 U.S.C. 802).

“Housing accommodation.” As used in Iowa Code chapter 216, the term “housing accommodation” has the same meaning as is given the term “dwelling” in this rule.

“Housing for older persons.” The exception found in Iowa Code section 216.12(4) is limited to discrimination based upon “familial status.”

Iowa Code section 216.15A(10) “c.” The word “continued” as used in this paragraph means “carried on or kept up without cessation.” This paragraph does not refer to the adjournment or postponement of a hearing to a subsequent date or time.

Iowa Code section 216.16A(1) “a.” Election to proceed in court. The election to have the charges of a complaint decided in a civil action as provided in Iowa Code section 216.16A(1) “a” is only available where:

1. It is alleged that there has been a violation of some portion of Iowa Code section 216.8 or 216.8A, or

2. It is alleged that there has been a violation of Iowa Code section 216.11 or 216.11A arising out of alleged violations of the prohibitions contained in Iowa Code section 216.8 or 216.8A.

Iowa Code section 216.16A(2). The phrase “mediation agreement” in Iowa Code section 216.16A(2) refers to the agreement described in Iowa Code section 216.15A(2) “a” to “e.”

“Person.” As used in the Iowa civil rights Act provisions relating to discrimination in housing, the term “person” includes one or more individuals, corporations, partnerships, associations, labor organizations, legal representatives, mutual companies, joint stock companies, trusts, unincorporated organizations, trustees, trustees in cases under Title 11 of the United States Code, receivers, and fiduciaries. The specific inclusion of an individual or entity within this definition of “person” does not imply that that individual or entity is excluded from the definition of “person” in Iowa Code section 216.2(11).

Referral and deferral to local agencies in housing cases. If a complaint alleges either a violation of the prohibitions contained in Iowa Code section 216.8 or 216.8A or a violation of Iowa Code section 216.11 or 216.11A arising out of alleged violations of the prohibitions contained in Iowa Code section 216.8 or 216.8A, then deferral and referral of that complaint to a local commission are governed by the provisions of Iowa Code section 216.5(14) and that section takes precedence over Iowa Code section 216.19.

161—9.4(216) Interpretation of provisions affecting court actions regarding alleged discriminatory housing or real estate practices occurring after July 1, 1991.

9.4(1) *Time limitation of rule.* This rule applies only to alleged discriminatory housing or real estate practices occurring after July 1, 1991.

9.4(2) *Aggrieved person’s direct action in district court.*

a. Filing of complaint not necessary. A complaint which alleges either (1) a violation of the prohibitions contained in Iowa Code section 216.8 or 216.8A, or (2) a violation of Iowa Code section 216.11 or 216.11A arising out of alleged violations of the prohibitions contained in Iowa Code section 216.8 or 216.8A need not be filed with the commission in order for an aggrieved person to seek judicial remedies for that alleged violation. An aggrieved person may file an action alleging such violations directly in district court pursuant to Iowa Code section 216.16A(2).

b. Effect of commission processing.

(1) In general. The status of commission processing of a complaint alleging a discriminatory housing or real estate practice does not affect the rights of an aggrieved party to file a civil action under Iowa Code section 216.16A(2) based on that same or any other alleged discriminatory housing or real estate practice.

(2) Exceptions. Commission processing will bar an aggrieved person from filing a civil action under Iowa Code section 216.16A(2) based on an alleged discriminatory housing or real estate practice only where either:

1. The commission has obtained a mediation agreement with the consent of that aggrieved person regarding that alleged discriminatory housing or real estate practice, or

2. The commission has begun a contested case hearing on the record regarding that same alleged discriminatory housing or real estate practice.

c. Notification of commission. If a person has filed a complaint alleging a discriminatory housing or real estate practice with the commission and that person subsequently commences a civil action under Iowa Code section 216.16A(2) based on that same alleged discriminatory housing or real estate practice,

the aggrieved person is encouraged to immediately notify the Iowa civil rights commission of the filing of the civil action.

d. Remedies. In an action filed directly in district court pursuant to Iowa Code section 216.16A(2), the court may, upon a finding of discrimination, order any of the remedies provided for in Iowa Code section 216.17A(6).

9.4(3) Election to proceed in district court.

a. In general. An aggrieved person on whose behalf a complaint was filed, a complainant, or a respondent may, pursuant to Iowa Code section 216.16A(1), elect to have the allegations asserted in the complaint decided in a civil action in district court. An election is made by filing a written notice of election with the commission. The date of filing of an election is the date the election is received by the commission at its offices in Des Moines. If such an election is made, the commission shall authorize and, within 30 days of the election, the attorney general shall file a civil action in district court on behalf of the aggrieved person. Failure to file within the 30-day period shall not, by itself, prejudice the rights of any of the parties.

b. Limitation. An election made under the previous paragraph must be made within 20 days of the receipt by the electing person of the determination of probable cause. The date of election is the date that the written notice of elections is filed with the commission.

c. Probable cause determination a prerequisite. No person may make an election pursuant to Iowa Code section 216.16A(1) until the commission has found probable cause regarding the complaint which is the subject of the election.

d. Notice required. An election to proceed in district court made under Iowa Code section 216.16A(1) is effective only if the electing person gives notice of the election to the commission and all other complainants and respondents to whom the election relates. Such notice shall be in writing, shall be delivered at the time the election is made, and may be made by regular mail.

e. Intervention. Once the commission commences an action in district court pursuant to Iowa Code section 216.17A(1) an aggrieved person may intervene in the action.

9.4(4) Right-to-sue letter inapplicable. A complainant need not, and should not, request a right-to-sue letter in order to file a civil action under Iowa Code section 216.16A(2) or to make an election as provided in Iowa Code section 216.16A(1).

9.4(5) Appointment of attorney by court. Upon application by a person alleging a discriminatory housing practice or a person against whom such a practice is alleged, the court may:

a. Appoint an attorney for the person, or

b. Authorize the commencement or continuation of a civil action under Iowa Code section 216.16A(2) without the payment of fees, costs, or security if, in the opinion of the court, the person is financially unable to bear the costs of such action.

161—9.5(216) Commission procedures regarding complaints based on alleged unfair or discriminatory practices occurring after July 1, 1991.

9.5(1) Time limitation of rule. This rule applies only to alleged discriminatory housing or real estate practices occurring after July 1, 1991.

9.5(2) Time limit for administrative complaint. A complaint which alleges a discriminatory housing or real estate practice is governed by the 300-day time limit provided in 2009 Iowa Code Supplement section 216.15(13).

9.5(3) Processing of complaint.

a. Service. Upon the filing of a complaint:

(1) The commission shall, not later than ten days after such filing or the identification of an additional respondent under 9.5(3)“d,” serve on the respondent a notice identifying the alleged discriminatory housing practice and advising the respondent of the procedural rights and obligations of respondents under the applicable sections of Iowa Code chapter 216, together with a copy of the original complaint; and

(2) Each respondent may file, not later than ten days after receipt of notice from the commission, an answer to the complaint.

(3) The commission shall, not later than ten days after the filing of a complaint, serve the complainant a notice acknowledging receipt of the complaint and advising the complainant of the time limits and choice of forums provided under Iowa Code chapter 216.

b. Timely investigation. The commission will begin the investigation within 30 days of filing. If the commission is unable to complete the investigation within 100 days after the filing of the complaint, the commission shall notify the complainant and respondent in writing of the reasons for not doing so.

c. Amendments. Complaints and answers shall be under oath or affirmation and may be reasonably and fairly amended at any time.

d. Additional respondents.

(1) A person who is not named as a respondent in a complaint, but who is identified as a respondent in the course of investigation, may be joined as an additional or substitute respondent upon written notice, under 9.5(3) "a," to such person from the commission.

(2) Such notice, in addition to meeting the requirements of 9.5(3) "a," shall explain the basis for the commission's belief that the person to whom the notice is addressed is properly joined as respondent.

e. Closure within one year. Within one year of the date of receipt of a complaint alleging a discriminatory housing or real estate practice, the commission shall take final administrative action with respect to that complaint unless it is impracticable to do so. If the commission is unable to make final disposition of the case within the one-year period, the commission shall notify the complainant and respondent in writing of the reasons for not doing so.

9.5(4) Probable cause determination.

a. Final investigative report. After the completion of the commission's investigation, the investigator shall prepare a final investigative report. This final investigative report shall include:

(1) The names and dates of contacts with witnesses excepting those witnesses who request to remain anonymous. The commission, however, may be required to disclose the names of such witnesses in the course of an administrative hearing or a civil action conducted pursuant to the Iowa civil rights Act;

(2) A summary and the dates of correspondence and other contacts with the aggrieved person and the respondent;

(3) A summary description of other pertinent records;

(4) A summary of witness statements; and

(5) Answers to interrogatories.

b. Determination procedure. If, after the completion of investigation, a mediation agreement under Iowa Code section 216.15A(2) "a" to "e" has not been executed by the complainant and the respondent and approved by the commission, the commission shall conduct a review of the factual circumstances revealed as part of the investigation.

(1) If the commission determines that, based on the totality of the factual circumstances known at the time of the commission's review, no probable cause exists to believe that a discriminatory housing practice has occurred or is about to occur, the commission shall: issue a short and plain written statement of the facts upon which the no probable cause determination was based; dismiss the complaint; notify the aggrieved person(s) and the respondent(s) of the dismissal (including the written statement of facts) by regular or certified mail or personal service; and make public disclosure of the dismissal.

Respondent(s) may request that no public disclosure be made. Notwithstanding such request, the fact of dismissal, including the names of the parties, shall be public information available on request.

The commission's determination shall be based solely on the facts concerning the alleged discriminatory housing practice provided by complainant and respondent(s) and otherwise disclosed during the investigation.

(2) If the commission believes that probable cause may exist to believe that a discriminatory housing practice has occurred or is about to occur, the commission shall forward the matter to the executive director or designee for consideration. In all such cases the executive director or designee shall determine, with advice from the office of the attorney general, whether, based on the totality of the factual circumstances known at the time of the decision, probable cause exists to believe that a discriminatory housing practice has occurred or is about to occur. The determination shall be based

solely on the facts concerning the alleged discriminatory housing practice provided by complainant and respondent and otherwise disclosed during the investigation.

c. Determination of probable cause. A determination of probable cause shall be followed by the issuance of a probable cause order. A probable cause order:

(1) Shall consist of a short and plain written statement of the facts upon which the commission has found probable cause to believe that a discriminatory housing practice has occurred or is about to occur;

(2) Shall be based on the final investigative report; and

(3) Need not be limited to facts or grounds that are alleged in the complaint. If the probable cause order is based on grounds that are alleged in the complaint, the commission will not issue the probable cause order with regard to those grounds unless the record of the investigation demonstrates that the respondent has been given an opportunity to respond to the allegation.

d. Timely determination. The commission shall make the probable cause determination within 100 days after the filing of the complaint unless it is impracticable to do so. If the commission is unable to make the determination within this 100-day period, the commission will notify the aggrieved person and the respondent by regular mail or personal service of the reasons for the delay.

e. Effect of probable cause determination. A finding of probable cause regarding a complaint alleging a discriminatory housing or real estate practice commences the running of the period during which an aggrieved person on whose behalf a complaint was filed, a complainant, or a respondent may, pursuant to Iowa Code section 216.16(1), elect to have the charges asserted in the complaint decided in a civil action in district court. If an election is made, the commission shall authorize the attorney general to file a civil action on behalf of the aggrieved person seeking relief. If no election is made, then the commission must schedule a hearing on the charges in the complaint.

f. Effect of no probable cause determination. A finding of “no probable cause” regarding a complaint alleging a discriminatory housing or real estate practice results in prompt dismissal of the complaint. If the finding is not reconsidered, the commission may take no further action to process that complaint except as may be necessary to carry out the commission’s administrative functions.

g. Standard. The standard to determine whether a complaint alleging a discriminatory housing or real estate practice is supported by probable cause shall include consideration of whether the facts are sufficient to warrant initiation of litigation against the respondent.

9.5(5) Hearing.

a. Conduct. A contested case hearing regarding a complaint alleging a discriminatory housing or real estate practice is conducted on the same terms and in the same manner as any other contested case hearing conducted by the commission.

b. Hearing time frames.

(1) Trial date. The administrative law judge shall commence the hearing regarding a complaint alleging a discriminatory housing or real estate practice no later than 120 days following the issuance of the finding of probable cause, unless it is impracticable to do so. If the administrative law judge is unable to commence the hearing within 120 days after the issuance of the probable cause order, the administrative law judge shall notify the executive director, the aggrieved person on whose behalf the charge was filed, and the respondent, in writing, of the reasons for not doing so.

(2) Decision date. The administrative law judge shall make findings of fact and conclusions of law within 60 days after the end of the hearing regarding a complaint alleging a discriminatory housing or real estate practice unless it is impracticable to do so. If the administrative law judge is unable to make findings of fact and conclusions of law within this period, or any succeeding 60-day period thereafter, the administrative law judge shall notify the executive director, the aggrieved person on whose behalf the charge was filed, and the respondent, in writing, of the reasons for not doing so.

9.5(6) Access to file information in housing cases.

a. Nothing that is said or done in the course of mediation of a complaint of housing or real estate discrimination may be made public or used as evidence in a subsequent administrative hearing under subrule 9.5(5) or in civil actions under Iowa Code chapter 216, without the written consent of the persons concerned.

9.7(2) *Supplementation of responses.* A party who has responded to a commission request for discovery is under a duty to supplement or amend the response to include information thereafter acquired as follows:

a. A party is under a duty seasonably to supplement the response with respect to any question directly addressed to:

- (1) The identity and location of persons having knowledge of discoverable matters; and
- (2) Any matter that bears materially upon a claim or defense asserted by any party.

b. A party is under a duty seasonably to amend a prior response if the party obtains information upon the basis of which:

- (1) The party knows that the response was incorrect when made; or
- (2) The party knows that the response though correct when made is no longer true and the circumstances are such that a failure to amend the response is in substance a knowing concealment.

161—9.8(216) Protective orders.

9.8(1) Upon motion by a party or by the person from whom discovery is sought or by any person who may be affected thereby, and for good cause shown, the presiding officer for discovery:

a. May make any order which justice requires to protect a party or other person from annoyance, embarrassment, oppression, or undue burden or expense, including one or more of the following:

- (1) That the discovery not be had;
- (2) That the discovery may be had only on specified terms and conditions, including a designation of the time or place;
- (3) That the discovery may be had only by a method of discovery other than that selected by the commission;
- (4) That certain matters not be inquired into, or that the scope of the discovery be limited to certain matters;
- (5) That discovery be conducted with no one present except persons designated by the presiding officer for discovery;
- (6) That a deposition after being sealed be opened only by order of a court, a commission contested case presiding officer, or the presiding officer for discovery;
- (7) That a trade secret or other confidential research, development, or commercial information not be disclosed or be disclosed only in a designated way;
- (8) That the parties simultaneously file specified documents or information enclosed in sealed envelopes to be opened as directed by the presiding officer for discovery.

b. Shall limit the frequency of use of the methods described in subrule 9.6(1) if the presiding officer for discovery determines that:

- (1) The discovery sought is unreasonably cumulative or duplicative, or is obtainable from some other source that is more convenient, less burdensome, or less expensive;
- (2) The commission has had ample opportunity by discovery in the action to obtain the information sought; or
- (3) The discovery is unduly burdensome or expensive, taking into account the needs of the case, the amount in controversy, limitations on the objecting party's resources, and the importance of the issues at stake in the investigation.

9.8(2) If the motion for a protective order is denied in whole or in part, the presiding officer for discovery may, on such terms and conditions as are just, order that any party or other person provide or permit discovery.

9.8(3) Award of expenses of motion. If the motion is granted, the presiding officer for discovery shall, after opportunity for hearing, require the commission, if it opposed the motion, to pay to the party or other person making the motion the reasonable expenses incurred in obtaining the order, including attorneys' fees, unless the presiding officer for discovery finds that the opposition to the motion was substantially justified or that other circumstances make an award of expenses unjust.

If the motion is denied, the presiding officer for discovery shall, after opportunity for hearing, require the party or deponent who made the motion or the party or attorney advising such a motion or both of them

to pay to the commission the reasonable expenses incurred in opposing the motion, including attorneys' fees, unless the presiding officer for discovery finds that the making of the motion was substantially justified or that other circumstances make an award of expenses unjust.

If the motion is granted in part and denied in part, the presiding officer for discovery may apportion in a just manner the reasonable expenses incurred in relation to the motion.

161—9.9(216) Interrogatories.

9.9(1) Availability; procedures for use. The commission may serve written interrogatories to be answered by a party or, if the party from whom the information is sought is a public or private corporation or a partnership or association or governmental agency, by any officer or agent, who shall furnish such information as is available to the party.

Each interrogatory shall be followed by a reasonable space for insertion of the answer. An interrogatory which does not comply with this requirement shall be subject to objection. The interrogatories must be accompanied by a written notice informing the person to whom the interrogatories are directed that a response is mandatory and that sanctions can be levied for a failure to respond.

Each interrogatory shall be answered separately and fully in writing under oath, unless it is objected to, in which event the reasons for objection shall be stated in lieu of an answer.

A party answering interrogatories must answer in the space provided or must set out each interrogatory immediately preceding the answer to it. A failure to comply with this rule shall be deemed a failure to answer and shall be subject to sanctions as provided in rule 161—9.16(216). Answers are to be signed by the person making them. Objections, if any, shall be served within 30 days after the interrogatories are served. The commission may move for an order under subrule 9.16(1) with respect to any objection to or other failure to answer an interrogatory.

The commission shall not serve more than 30 interrogatories on any party under the authority of this rule except upon agreement by the person from whom information is sought or leave of the presiding officer for discovery granted upon a showing of good cause. A motion for leave to serve more than 30 interrogatories must be in writing and shall set forth the proposed interrogatories and the reasons establishing good cause for their use.

Notwithstanding the provisions of this subrule the commission may, without limitation on the number of questions, solicit information from the parties in the form of a written questionnaire. The response to these questions, however, cannot be compelled under rule 161—9.16(216).

9.9(2) Scope. An interrogatory otherwise proper is not necessarily objectionable merely because an answer to the interrogatory involves an opinion or contention that relates to fact or the application of law to fact, but the presiding officer for discovery may order that such an interrogatory need not be answered until a later time.

9.9(3) Option to produce business records. Where the answer to an interrogatory may be derived or ascertained from the business records of the party upon whom the interrogatory has been served or from an examination, audit or inspection of such business records, or from a compilation, abstract or summary based thereon, and the burden of deriving or ascertaining the answer is substantially the same for the commission as for the party served, it is a sufficient answer to such interrogatory to specify the records from which the answer may be derived or ascertained and to afford to the commission reasonable opportunity to examine, audit or inspect such records and to make copies, compilations, abstracts or summaries. A specification shall be in sufficient detail to permit the commission to locate and identify as readily as can the party served, the records from which the answer may be ascertained.

161—9.10(216) Requests for admission.

9.10(1) Availability; procedures for requests. The commission may serve upon any party a written request for the admission, for purposes of all proceedings relating to the pending complaint only, of the truth of any matters within the scope of rule 161—9.7(216) set forth in the request that relate to statements or opinions of fact or of the application of law to fact, including the genuineness of any

documents described in the request. Copies of documents shall be served with the request unless they have been or are otherwise furnished or made available for inspection and copying.

Each matter of which an admission is requested shall be separately set forth.

Notice of the effect of an admission shall be given to the person from whom the admission is sought.

The commission shall not serve more than 30 requests for admission on any party except upon agreement of the party from whom admissions are sought or leave of the presiding officer for discovery granted upon a showing of good cause. A motion for leave of the presiding officer for discovery to serve more than 30 requests for admission must be in writing and shall set forth the proposed requests and the reasons establishing good cause for their use.

9.10(2) *Time for and content of responses.* The matter is admitted unless, within 30 days after service of the request, or within such shorter or longer time as the presiding officer for discovery may on motion allow, the party to whom the request is directed serves upon the commission a written answer or objection addressed to the matter, signed by the party or by the party's attorney.

If objection is made, the reasons therefor shall be stated. The answer shall specifically deny the matter or set forth in detail the reasons why the answering party cannot truthfully admit or deny the matter. A denial shall fairly meet the substance of the requested admission, and when good faith requires that a party qualify the party's answer or deny only a part of the matter of which an admission is requested, the party shall specify so much of it as is true and qualify or deny the remainder. An answering party may not give lack of information or knowledge as a reason for failure to admit or deny unless the party states that the party has made reasonable inquiry and that the information known or readily obtainable by the party is insufficient to enable the party to admit or deny. A party who considers that a matter of which an admission has been requested presents a genuine issue for trial may not, on that ground alone, object to the request; the party may, subject to the provisions of subrule 9.16(3), deny the matter or set forth reasons why the party cannot admit or deny it.

9.10(3) *Determining sufficiency of responses.* The commission may move to determine the sufficiency of the answers or objections. Unless the presiding officer for discovery determines that an objection is justified, the presiding officer for discovery shall order that an answer be served. If the presiding officer for discovery determines that an answer does not comply with the requirements of this rule, the presiding officer for discovery may order either that the matter be admitted or that an amended answer be served. The presiding officer for discovery may, in lieu of these orders, determine that final disposition of the request be made at a designated time prior to completion of the investigation. The provisions of paragraph 9.16(1) "d" apply to the award of expenses incurred in relation to the motion.

161—9.11(216) Effect of admission. Any matter admitted under rule 161—9.10(216) is conclusively established in all proceedings relating to the pending complaint unless the court or contested case administrative law judge on motion permits withdrawal or amendment of the admission. The court or contested case administrative law judge may permit withdrawal or amendment when the presentation of the merits of the action will be subserved thereby and the commission or the party opposing the motion fails to satisfy the court or contested case administrative law judge that withdrawal or amendment will prejudice the commission in maintaining the commission's action on the merits.

161—9.12(216) Production of documents and things and entry upon land for inspection and other purposes. The commission may serve on any party a request:

9.12(1) To produce and permit the commission, or someone acting on the commission's behalf, to inspect and copy any designated documents (including writings, drawings, graphs, charts, photographs, and other data compilations from which information can be obtained, translated, if necessary, by the party upon whom the request is served through detection devices into reasonably usable form), or to inspect and copy, test, or sample any tangible things which constitute or contain matters within the scope of rule 161—9.7(216) and which are in the possession, custody or control of the party upon whom the request is served; or

9.12(2) Except as otherwise provided by statute, to permit entry upon designated land or other property in the possession or control of the party upon whom the request is served for the purpose

of inspection and measuring, surveying, photographing, testing, or sampling the property or any designated object or operation thereon, within the scope of rule 161—9.7(216).

161—9.13(216) Procedures for documents and inspections. The request shall set forth the items to be inspected either by individual item or by category and describe each item and category with reasonable particularity. The request shall specify a reasonable time, place, and manner of making the inspection and performing the related acts.

The party upon whom the request is served shall serve a written response within 30 days after the service of the request. The presiding officer for discovery may allow a shorter or longer time. The response shall state, with respect to each item or category, that inspection and related activities will be permitted as requested, unless the request is objected to, in which event the reasons for objection shall be stated. If objection is made to part of an item or category, the part shall be specified.

The commission may move for an order under rule 161—9.16(216) with respect to any objection to or other failure to respond to the request or any part thereof, or any failure to permit inspection as requested.

161—9.14(216) Physical and mental examination of persons. When the mental or physical condition (including the blood group) of a party, or of a person in the custody or under the legal control of a party, is in controversy, the presiding officer for discovery may order the party to submit to a physical or mental examination by a health care practitioner or to produce for examination the person in the party's custody or legal control. The order may be made only on motion of the commission for good cause shown and upon notice to the person to be examined and to all parties and shall specify the time, place, manner, conditions, and scope of the examination and the person or persons by whom it is to be made.

161—9.15(216) Report of health care practitioner.

9.15(1) If requested by the party against whom an order is made under rule 161—9.14(216) or the person examined, the commission shall deliver a copy of the examiner's detailed written report setting out the findings, including results of all tests made, diagnosis and conclusions, together with like reports of all earlier examinations of the same condition. After delivery, if requested by the commission, the party against whom the order is made shall deliver a like report of any examination of the same condition, previously or thereafter made, unless the party shows an inability to obtain a report of examination of a nonparty. The presiding officer for discovery on motion may order a party or the commission to deliver a report on such terms as are just. If an examiner fails or refuses to make a report, a court or administrative law judge hearing a case based on the complaint at issue may exclude the examiner's testimony.

9.15(2) By requesting and obtaining a report of the examination so ordered, the party examined waives any privilege the party may have in that action or any other proceeding involving the same controversy, regarding the testimony of every other person who has examined or may thereafter examine the party in respect of the same mental or physical condition.

9.15(3) This rule applies to examination made by agreement, unless the agreement expressly provides otherwise.

161—9.16(216) Consequences of failure to make discovery.

9.16(1) Motion for order compelling discovery. The commission, upon reasonable notice to the party from whom discovery was sought and all persons affected thereby, may move for an order compelling discovery as follows:

a. Appropriate officer. A motion to compel discovery shall be made to the presiding officer for discovery.

b. Motion. If a deponent fails to answer a question propounded or submitted under rule 161—9.17(216), or a corporation or other entity fails to make a designation under subrule 9.18(5), or a party fails to answer an interrogatory submitted under rule 161—9.9(216), or if a party, in response to a request for inspection submitted under rule 161—9.12(216), fails to respond that inspection will be permitted as requested or fails to permit inspection as requested, the commission may move for

an order compelling an answer, a designation, or an inspection in accordance with the request. When taking a deposition on oral examination, the commission may complete or adjourn the examination before moving for an order.

Any order granting a motion made under this rule shall include a statement that a failure to comply with the order may result in the imposition of sanctions pursuant to rule 161—9.16(216).

In ruling on such motion, the presiding officer for discovery may make such protective order as the presiding officer for discovery would have been empowered to make on a motion pursuant to subrule 161—9.8(1).

c. Evasive or incomplete answer. For purposes of this subrule an evasive or incomplete answer is to be treated as a failure to answer.

d. Award of expenses of motion. If the motion is granted, the presiding officer for discovery shall, after opportunity for hearing, require the party or deponent whose conduct necessitated the motion or the party or attorney advising such conduct or both of them to pay to the commission the reasonable expenses incurred in obtaining the order, including attorneys' fees, unless the presiding officer for discovery finds that the opposition to the motion was substantially justified or that other circumstances make an award of expenses unjust.

If the motion is denied, the presiding officer for discovery shall, after opportunity for hearing, require the commission to pay to the party or deponent who opposed the motion the reasonable expenses incurred in opposing the motion, including attorneys' fees, unless the presiding officer for discovery finds that the making of the motion was substantially justified or that other circumstances make an award of expenses unjust.

If the motion is granted in part and denied in part, the presiding officer for discovery may apportion in a just manner the reasonable expenses incurred in relation to the motion.

e. Notice to party. If the motion is granted, the presiding officer for discovery shall mail or cause to have mailed a copy of the order to counsel and to the party or parties whose conduct, individually or by counsel, necessitated the motion.

9.16(2) Failure to comply with order.

a. Sanctions by court in district where deposition is taken. If a deponent fails to be sworn or to answer a question after being directed to do so by the presiding officer for discovery, the office of the attorney general may petition for enforcement of that order in the judicial district in which the deposition is being taken. Failure by the deponent to obey an order of enforcement from the district court may be considered a contempt of that court.

b. Sanctions by the presiding officer for discovery. If a party or an officer, director, or managing agent of a party or a person designated under subrule 9.18(5) to testify on behalf of a party fails to obey an order to provide or permit discovery, including an order made under 9.16(1) or under rule 161—9.14(216), the presiding officer for discovery may make such orders in regard to the failure as are just, and among others, the following:

(1) An order that the matters regarding which the order was made or any other designated facts shall be taken to be established for the purposes of any action or proceeding relating to the subject matter of the investigation in accordance with the claim of the party opposing the position of the disobedient party;

(2) An order refusing to allow the disobedient party to support or oppose designated claims or defenses, or prohibiting such party from introducing designated matters in evidence in any action or proceeding relating to the subject matter of the investigation;

(3) An order striking out pleadings or parts thereof, or staying further proceedings until the order is obeyed, or dismissing the action or proceeding or any part thereof, or rendering a judgment by default against the disobedient party;

(4) In lieu of any of the foregoing orders or in addition thereto, the presiding officer for discovery shall require the disobedient party or the attorney advising such party or both to pay the reasonable expenses, including attorneys' fees, caused by the failure, unless the presiding officer for discovery finds that the failure was substantially justified or that other circumstances make an award of expenses unjust.

c. Enforcement petition. In addition to any of the alternatives of paragraph “b” above, the office of the attorney general may petition for enforcement of the order compelling discovery in the appropriate judicial district. Failure by a party to obey an order of enforcement from the district court may be considered a contempt of that court.

9.16(3) Expenses on failure to admit. If a party fails to admit the genuineness of any document or the truth of any matter as requested under rule 161—9.10(216), and if the commission thereafter proves the genuineness of the document or the truth of the matter, the commission may move for an order requiring the party to pay the reasonable expenses incurred in making that proof, including reasonable attorneys’ fees. The presiding officer for discovery shall make the order unless the presiding officer for discovery finds that:

- a.* The request was held objectionable pursuant to rule 161—9.10(216),
- b.* The admission sought was of no substantial importance,
- c.* The party failing to admit had reasonable ground to believe that the party might prevail on the matter, or
- d.* There was other good reason for the failure to admit.

9.16(4) Failure of party to attend at own deposition or serve answers to interrogatories or respond to request for inspection. If a party or an officer, director, or managing agent of a party or a person designated under subrule 9.18(5) to testify on behalf of a party fails to appear before the officer who is to take the person’s deposition, after being served with a proper notice; or to serve answers or objections to interrogatories submitted under rule 161—9.9(216), after proper service of the interrogatories; or to serve a written response to a request for inspection submitted under rule 161—9.12(216), after proper service of the request, the presiding officer for discovery on motion of the commission may make such orders in regard to the failure as are just, and among others it may take any action authorized under 9.16(2) “b”(1) to (4).

The failure to act described in this subrule may not be excused on the ground that the discovery sought is objectionable unless the party failing to act has applied for a protective order as provided by rule 161—9.8(216).

9.16(5) Motions relating to discovery. No motion relating to depositions or discovery shall be filed or considered by the presiding officer for discovery unless the motion alleges that the movant has made a good-faith but unsuccessful attempt to resolve the issues raised by the motion with counsel for the party or entity whom the motion concerns without intervention of the presiding officer for discovery.

161—9.17(216) Depositions upon oral examination.

9.17(1) When depositions may be taken. The commission may take a deposition in an investigation of a complaint of housing discrimination at any time during the pendency of that investigation.

9.17(2) Recording. The administrative law judge charged with the duty of determining probable cause under Iowa Code subsection 216.15(3) may order that the testimony at such an investigative deposition be recorded by other than stenographic means, in which event the order shall designate the manner of recording the deposition, and may include other provisions to ensure that the recorded testimony will be accurate and trustworthy. If the order is made, the party from whom discovery is sought or the deponent may nevertheless arrange to have a stenographic transcription made at that party’s or deponent’s own expense. An order of the administrative law judge is not required to record testimony by nonstenographic means if the deposition is also to be recorded stenographically.

9.17(3) Place of deposition.

- a.* Oral depositions may be taken only within this state.
- b.* If the deponent is a party or the officer, partner or managing agent of a party which is not a natural person, the deponent shall be required to submit to examination in Polk County, unless otherwise ordered by the presiding officer for discovery.

9.17(4) Failure to attend; expenses. If the commission official fails to attend and proceed with a noticed deposition and the party from whom discovery is sought attends in person or by attorney pursuant to the notice, the presiding officer for discovery may order the commission to pay to such party

the reasonable expenses incurred by the party and the other party's attorney in attending, including reasonable attorneys' fees.

9.17(5) *Depositions by telephone.* Any deposition permitted by these rules may be taken by telephonic means.

When the commission intends to take the deposition of any person upon oral examination by telephonic means, the commission shall give reasonable notice thereof in writing to any party who is to be deposed and to any other deponent. Such notice shall contain all other information required by subrule 9.18(1) and shall state that the telephone conference will be arranged and paid for by the commission. No part of the expense for telephone service shall be taxed as costs.

If the commission desires to present exhibits to the witness during the deposition, copies shall be sent to the deponent and any party who is to be deposed, prior to the taking of the deposition.

Nothing in this rule shall prohibit a party from whom the discovery is sought or counsel for that party or for the deponent from being in the presence of the deponent when the deposition is taken.

161—9.18(216) Notice for oral deposition.

9.18(1) Whenever the commission desires to take the deposition of any person upon oral examination, the commission shall give reasonable notice in writing to the deponent and any party who is to be deposed. The notice shall state the time and place for taking the deposition and the name and address of each person to be examined, if known, and, if the name is not known, a general description sufficient to identify the person or the particular class or group to which the person belongs.

9.18(2) If a subpoena duces tecum is to be served on the person to be examined, the designation of the materials to be produced as set forth in the subpoena shall be attached to or included in the notice.

9.18(3) The notice to a party deponent may be accompanied by a request made in compliance with rules 161—9.12(216) and 161—9.13(216) for the production of documents and tangible things at the taking of deposition. The procedure of rule 161—9.13(216) shall apply to the request.

9.18(4) No subpoena is necessary to require the appearance of a party for a deposition. Service on the party or the party's attorney of record of notice of the taking of a deposition of the party or of an officer, partner or managing agent of any party who is not a natural person, as provided in 9.18(1), is sufficient to require the appearance of a deponent for the deposition.

9.18(5) A notice or subpoena may name as the deponent a public or private corporation or a partnership or association or governmental agency and describe with reasonable particularity the matters on which examination is requested. In that event, the organization so named shall designate one or more officers, directors, or managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the witness will testify. A subpoena shall advise a nonparty organization of its duty to make such a designation. The persons so designated shall testify as to matters known or reasonably available to the organization. This subrule does not preclude taking a deposition by any other procedure authorized in these rules.

161—9.19(216) Conduct of oral deposition.

9.19(1) *Examination; recording examination; administering the oath; objections.* Examination of witnesses by the commission may proceed as permitted at the hearing. The commission investigator or other officer before whom the deposition is to be taken shall put the witness under oath and shall personally, or by someone acting under the investigator or officer's direction and in the investigator or officer's presence, record the testimony of the witness. The testimony shall be taken stenographically or recorded by any other means ordered in accordance with subrule 9.17(2). All objections made at the time of the examination to the qualifications of the investigator or other officer taking the deposition, or to the manner of taking it, or to the evidence presented, or to the conduct of any party, and any other objection to the proceedings, shall be noted by the investigator or officer upon the deposition. Evidence objected to shall be taken subject to the objections.

9.19(2) *Motion to terminate or limit examination.* At any time during the taking of the deposition, on motion of the party being deposed or other deponent and upon a showing that the examination is being conducted in bad faith or in such manner as unreasonably to annoy, embarrass, or oppress the deponent

or party, the presiding officer for discovery may order the commission to cease forthwith from taking the deposition, or may limit the scope and manner of the taking of the deposition as provided in rule 161—9.8(216). If the order made terminates the examination, it shall be resumed thereafter only upon the order of the presiding officer for discovery. Upon demand of the objecting party or deponent, the taking of the deposition shall be suspended for the time necessary to make a motion for an order.

If the motion is granted, the presiding officer for discovery shall, after opportunity for hearing, require the commission to pay to the moving party the reasonable expenses incurred in obtaining the order, including attorneys' fees, unless the presiding officer for discovery finds that the opposition to the motion was substantially justified or that other circumstances make an award of expenses unjust.

If the motion is denied, the presiding officer for discovery shall, after opportunity for hearing, require the moving party or the attorney advising the motion or both of them to pay to the commission the reasonable expenses incurred in opposing the motion, including attorneys' fees, unless the presiding officer for discovery finds that the making of the motion was substantially justified or that other circumstances make an award of expenses unjust.

If the motion is granted in part and denied in part, the presiding officer for discovery may apportion in a just manner the reasonable expenses incurred in relation to the motion.

161—9.20(216) Reading and signing depositions.

9.20(1) *Where reading or signing not required.* No oral deposition reported and transcribed by an official court reporter or certified shorthand reporter of Iowa need be submitted to, read or signed by the deponent.

9.20(2) *Submission to witness; changes; signing.* In other cases, if and when the testimony is fully transcribed, the deposition shall be submitted to the witness for examination and shall be read to or by the witness, unless such examination and reading are waived by the witness. Any changes in form or substance which the witness desires to make shall be entered upon the deposition by the officer with a statement of the reasons given by the witness for making them. The deposition shall then be signed by the witness, unless the witness is ill or dead or cannot be found or refuses to sign. If the deposition is not signed by the witness within 30 days of its submission, the investigator or officer shall sign it and state on the record the fact of the waiver or of the illness, death, or absence of the witness or the fact of the refusal to sign together with the reason, if any, given therefor. The deposition may then be used as fully as though signed unless on a motion to suppress the tribunal hearing the motion holds that the reason given for the refusal to sign requires rejection of the deposition in whole or in part.

161—9.21(216) Certification and return; copies.

9.21(1) When the deposition is transcribed, the investigator or other officer shall certify on the deposition that the witness was duly sworn and that the deposition is a true record of the testimony given by the witness. Documents and things produced for inspection during the deposition shall, upon the request of the investigator, be marked for identification and annexed to the deposition, except that:

a. The person producing the materials may substitute copies to be marked for identification, if the investigator is provided fair opportunity to verify the copies by comparison with the originals;

b. If the person producing the materials requests their return, the investigator shall mark, copy, and, at some time prior to the completion of the investigation, return them to the person producing them. The materials may then be used in the same manner as if annexed to the deposition.

9.21(2) Upon payment of reasonable charges therefor, the commission shall furnish a copy of the deposition to the party who was deposed or to the deponent.

161—9.22(216) Before whom taken. The officer taking the deposition shall not be a party, a person financially interested in the action, an attorney or employee of any party, an employee of any such attorney, or any person related within the fourth degree of consanguinity or affinity to a party, a party's attorney, or an employee of either of any party.

161—9.23(216) Deposition subpoena.

9.23(1) The commission may issue subpoenas for persons named in and described in a notice to take depositions under rule 161—9.18(216). Subpoenas may also be issued as provided by statute or by rule 161—3.14(216).

9.23(2) No resident of Iowa shall be subpoenaed to attend a deposition out of the county where the deponent resides, or is employed, or transacts business in person.

161—9.24(216) Costs of taking deposition. Costs of taking and proceeding to procure a deposition shall be paid by the commission.

161—9.25(216) Irregularities and objections.

9.25(1) Notice. All objections to any notice of taking any depositions are waived unless promptly served in writing upon the commission.

9.25(2) Officer. Objection to the commission investigator or other officer's qualification to take a deposition is waived unless made before such taking begins, or as soon thereafter as objector knows it or could discover it with reasonable diligence.

9.25(3) Taking depositions. Errors or irregularities occurring during an oral deposition as to any conduct or manner of taking it, or the oath, or the form of any question or answer, and any other errors which might thereupon have been cured, obviated or removed, are waived unless seasonably objected to during the deposition.

161—9.26(216) Service of discovery. Service of documents pertaining to discovery procedures described in this chapter, other than subpoenas, may be accomplished by the same means as in rule 161—4.6(17A).

161—9.27(216) Appeals. Appeals from an imposition of sanctions by the presiding officer for discovery under rule 161—9.16(216) are filed and processed in the same manner as appeals under rule 161—4.23(17A). Appeals from other decisions rendered by the presiding officer for discovery are filed and processed in the same manner as appeals under rule 161—4.25(17A).

161—9.28(216) Representation of commission. At all discovery hearings, motions, and appeals, including those proceedings before the presiding officer for discovery, the commission may be represented by a member of the attorney general's office.

These rules are intended to implement Iowa Code sections 216.5(13), 216.8 and 216.8A.

Appendix A
Form 1

Request for Assistance Animal as a Reasonable Accommodation in Housing:
Health Care Professional Form

Requester's Name: _____

Address: _____

Telephone: _____ E-mail: _____

I, _____, intend to request that _____ permit me to keep an assistance animal as a reasonable accommodation in housing for my disability. In connection with that application, I am requesting that you complete this form regarding my disability.

Requester's Signature

Date

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

1. Does the individual identified above have a disability?
 Yes No
2. If yes, is the need for an assistance animal related to that disability? For example, does or would an assistance animal alleviate one or more of the symptoms or effects of the disability?
 Yes No

By signing below, the undersigned health care professional/licensee certifies that he/she 1) has met with the patient or client in person or by telemedicine, 2) is sufficiently familiar with the patient or client and the disability, **and** 3) is legally and professionally qualified to make the finding.

Health Care Provider's Name (printed): _____

Signature: _____

Date: _____

References: Iowa Code sections 216.8B and 216.8C

Resources: <https://icrc.iowa.gov/>, 515-281-4121, 1-800-457-4416

This document may contain privileged and confidential information and/or protected health information intended solely for the use by the recipient housing provider. Please exercise care to avoid dissemination.

[ARC 4970C, IAB 3/11/20, effective 4/15/20]

[Filed 7/17/92, Notice 6/10/92—published 8/5/92, effective 9/9/92]

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[Filed ARC 4970C (Notice ARC 4551C, IAB 7/17/19), IAB 3/11/20, effective 4/15/20]

CHAPTER 71
TARGETED JOBS WITHHOLDING TAX CREDIT PROGRAM

261—71.1(403) Definitions.

“*Act*” means Iowa Code section 403.19A.

“*Authority*” means the economic development authority.

“*Award date*” means the same as defined in 261—Chapter 173.

“*Base employment level*” means the same as defined in 261—Chapter 173.

“*Board*” means the members of the authority appointed by the governor and in whom the powers of the authority are vested pursuant to Iowa Code section 15.105.

“*Business*” means an enterprise that is located in this state and that is operated for profit and under a single management. “Business” includes professional services and industrial enterprises, including but not limited to medical treatment facilities, manufacturing facilities, corporate headquarters, and research facilities. “Business” does not include a retail operation, a government entity, or a business which closes or substantially reduces its operation in one area of this state and relocates substantially the same operation to another area of this state.

“*Countywide average wage*” means the average that the authority calculates using the most current four quarters of wage and employment information as provided in the quarterly covered wage and employment data report as provided by the department of workforce development. Agricultural/mining and governmental employment categories are deleted in compiling the wage information.

“*Created job*” means the same as defined in 261—Chapter 173.

“*Due diligence committee*” or “*DDC*” means the due diligence committee organized by the board pursuant to 261—Chapter 1.

“*Employee*” means the individual employed in a targeted job that is subject to a withholding agreement.

“*Employer*” means a business creating or retaining targeted jobs in a pilot project city pursuant to a withholding agreement.

“*Employer’s taxable capital investment*” means a capital investment in real property, including but not limited to the purchase of land and existing buildings and building construction included in the project, that is subject to taxation by the local taxing authority.

“*Full-time equivalent job*” or “*full-time*” means the same as defined in 261—Chapter 173.

“*Local financial support*” or “*local match*” means cash or in-kind contributions to be used for the project from a private donor, a business, or the pilot project city. “Cash” includes but is not limited to loans, forgivable loans or grants. “In-kind contributions” means contributions directly related to the project and includes but is not limited to the construction of private or public infrastructure or other amenities and improvements.

“*Pilot project city*” means a city that has applied and been approved as a pilot project city pursuant to rule 261—71.2(403).

“*Project initiation*” means the same as defined in 261—Chapter 173.

“*Qualifying investment*” means a capital investment in real property including the purchase price of land and existing buildings, site preparation, building construction, and long-term lease costs. “Qualifying investment” also means a capital investment in depreciable assets. For purposes of this paragraph, “long-term lease costs” means those costs incurred or expected to be incurred under a lease during the duration of a withholding agreement, provided that the cumulative cost for that period does not exceed the cost of the land and the third-party developer’s costs to build or renovate the building for the approved business.

“*Retained job*” means a full-time equivalent position in existence at the time an employer applies to the authority for approval of a withholding agreement and which remains continuously filled and which is at risk of elimination if the project for which the employer is seeking assistance under the withholding agreement does not proceed. For the purposes of this definition, a position “at risk of elimination” includes a position that would be relocated out of state.

“*Targeted job*” means a job in a business which is or will be located in a pilot project city that pays a wage at least equal to the countywide average wage. “Targeted job” includes new or retained jobs from Iowa business expansions or retentions within the city limits of the pilot project city and those jobs resulting from established out-of-state businesses, as defined by the authority, that are moving to or expanding in Iowa.

“*Urban renewal area*” means the same as defined in Iowa Code section 403.17.

“*Withholding agreement*” means an agreement authorized in rule 261—71.4(403) between a pilot project city, the authority, and an employer concerning the targeted jobs withholding tax credit and that includes an application for a project that is the subject of a withholding agreement.

[ARC 7561B, IAB 2/11/09, effective 3/18/09 (See Delay note at end of chapter); ARC 7848B, IAB 6/17/09, effective 7/1/09; ARC 8147B, IAB 9/23/09, effective 10/28/09; ARC 1373C, IAB 3/19/14, effective 2/24/14]

261—71.2(403) Eligibility requirements. An eligible city may apply to the authority to be designated as a pilot project city. An eligible city is a city that contains three or more census tracts and is located in a county meeting one of the following requirements:

1. A county that borders Nebraska.
2. A county that borders South Dakota.
3. A county that borders a state other than Nebraska or South Dakota.

[ARC 7561B, IAB 2/11/09, effective 3/18/09 (See Delay note at end of chapter); ARC 1373C, IAB 3/19/14, effective 2/24/14]

261—71.3(403) Pilot project city application process and review.

71.3(1) Application. The authority shall develop a standardized application and make the application available to eligible cities. The application procedures are as follows:

a. An eligible city seeking approval as a pilot project city will submit an application to the authority. The authority shall determine if the application is complete.

b. The authority will review the application and consider the following criteria:

(1) Need for pilot project status. The city shall demonstrate why status as a pilot project city is necessary, including how the city will utilize the program to attract and retain employers.

(2) Planned and current projects. The city shall provide information on planned and current economic development projects that are taking place or will take place in a pilot project city. The city shall demonstrate its ability to enter into a withholding agreement with an eligible business within one year of the city’s approval as a pilot project city.

(3) Use of withholding funds. If approved as a pilot project city, the city shall indicate how the city plans to utilize withholding funds generated from the program. The city shall provide an estimate of the number of withholding agreements the city anticipates executing, the amount of withholding funds the city expects to generate as a result of the program, and the investment to be leveraged by use of the program.

(4) Matching funds. The city shall identify its ability to provide matching funds for projects involving withholding credits, including the potential sources of matching funds.

c. A resolution of support from the city applying for approval as a pilot project city is required as part of the application. This resolution shall include approval of the submission of the application to the authority for status as a pilot project city.

d. The authority may request additional information from a city that is applying for pilot project city status or may use other resources to obtain the needed information.

e. Applications filed on or after October 1, 2006, shall not be considered.

71.3(2) Approval of applications. The authority shall approve four eligible pilot project cities: one pursuant to 71.2“1,” one pursuant to 71.2“2,” and two pursuant to 71.2“3.” If more than two cities meeting the requirements of 71.2“3” apply to be designated as a pilot project city, the department of management, in consultation with the authority, shall determine which two cities hold the most potential to create new jobs or generate the greatest capital in their areas. Authority staff will prepare a recommendation for each of the cities to be approved as pilot project cities. The board will make the final decision to approve, defer or deny applications. Once applications are approved by the board, all communities applying for pilot project city status will be notified of the status of their applications.

71.3(3) Status as a pilot project city. If a pilot project city does not enter into a withholding agreement within one year of its approval as a pilot project city, the city shall lose its status as a pilot project city. Upon such occurrence, the authority shall take applications from other eligible cities to replace that city. Another city shall be designated within six months.

[ARC 7561B, IAB 2/11/09, effective 3/18/09 (See Delay note at end of chapter); ARC 1373C, IAB 3/19/14, effective 2/24/14]

261—71.4(403) Withholding agreements.

71.4(1) Designated account. An approved pilot project city may provide by city resolution for the deposit of funds generated through withholding agreements into a designated withholding project fund under the targeted jobs withholding tax credit program.

71.4(2) Entering into a withholding agreement.

a. Agreement between a pilot project city, the authority, and a business. The authority and a pilot project city may enter into a withholding agreement with a business locating to the community from another state that is creating or retaining targeted jobs in a pilot project city. The authority and a pilot project city may enter into a withholding agreement with a business currently located in Iowa only if the business is creating or retaining at least ten jobs or making a qualifying investment of at least \$500,000 within the pilot project city.

b. Total amount of withholding tax credits. The withholding agreement shall provide for the total amount of withholding tax credits awarded, as negotiated by the economic development authority, the pilot project city, and the employer. An agreement shall not provide for an amount of withholding tax credits that exceeds the amount of qualifying investment made in the project.

c. Ineligibility if there is competition between pilot project city and non-pilot project city. A withholding agreement shall not be entered into with an employer not already located in a pilot project city when another Iowa community is competing for the same project and both the pilot project city and the other Iowa community are seeking assistance from the authority.

d. Option of a business to enter into withholding agreement. A business shall not be obligated to enter into a withholding agreement with a pilot project city and the authority.

e. Board approval of withholding agreements. Prior to entering into a withholding agreement with a business, a pilot project city shall request board approval of the withholding agreement. The process for requesting approval from the board is described in subrule 71.5(1).

71.4(3) Required components of a withholding agreement. A withholding agreement shall be disclosed to the public and shall contain all of the following:

a. A copy of the adopted local development agreement between the pilot project city and employer that outlines local incentives or assistance for the project using urban renewal or urban revitalization incentives, if applicable, and how withholding funds generated by the city will be used.

b. A list of all other incentives or financial assistance the business has requested or is receiving from other federal, state, or local economic development programs including loans, grants, forgivable loans, and tax credits.

c. The amount of assistance provided by the pilot project city for the project.

d. Documentation of the approval of the project by local participating authorities.

e. The total amount of withholding tax credits awarded.

f. The total number of created and retained jobs included in the project.

g. The required countywide average wage.

h. The total qualifying investment included in the project.

i. The total required matching local financial support for the project.

71.4(4) Length of withholding agreements. A withholding agreement may have a term of up to ten years, as negotiated by the authority, the pilot project city, and the employer. A withholding agreement specifying a term of years or a total amount of withholding credits shall either terminate upon the expiration of the term of years specified in the agreement or upon the award of the total amount of withholding credits specified in the agreement, whichever occurs first.

71.4(5) Withholding generated through the program.

a. Once a pilot project city, the authority, and an employer have entered into a withholding agreement, an amount equal to 3 percent of the gross wages paid by the business to each employee under a withholding agreement shall be credited from the payment made by the employer pursuant to Iowa Code section 422.16. If the amount of withholding by the employer is less than 3 percent of the gross wages paid to the employees covered by the withholding agreement, the employer shall receive a credit against other withholding taxes due by the employer or may carry the credit forward for up to ten years or until depleted, whichever occurs first.

b. The employer shall submit the amount of the credit quarterly, in the same manner as withholding payments are made to the department of revenue, to the pilot project city.

c. An employee whose wages are subject to a withholding agreement shall receive full credit for the amount withheld under the targeted jobs withholding tax credit program as provided in Iowa Code section 422.16.

71.4(6) *Use of withholding funds.* A pilot project city shall allocate the withholding funds into a designated withholding project fund for the project. All funds deposited shall be used or pledged by the pilot project city for a project related to the employer pursuant to the withholding agreement.

71.4(7) *Local match requirement.* The intent of the program is to require a pilot project city to contribute to projects that result in an increase in the city's tax collections. If a pilot project city realizes an increase in tax revenues due to the project, then the pilot project city is required to contribute at least 10 percent of the required local match. For example, if a project includes the purchase and remodeling of a building that results in increased tax collections to the pilot project city by an amount equal to 10 percent of the total amount of the withholding tax credit award, then the pilot project city is required to contribute at least 10 percent of the required local match for the project. In cases in which a project would include the purchase of a building but there is no increase in tax collections to the pilot project city, the pilot project city is not required to contribute to the required local match.

a. A pilot project city entering into a withholding agreement shall arrange for matching local financial support for the project. The local match required shall be in an amount equal to one dollar for every one dollar of withholding tax credit received by the pilot project city.

b. If the project, when completed, will increase the amount of an employer's taxable capital investment by an amount equal to at least 10 percent of the amount of withholding tax credit dollars received by the pilot project city, then the pilot project city shall itself contribute at least 10 percent of the local match amount computed under paragraph "a."

c. If the project, when completed, will not increase the amount of the employer's taxable capital investment by an amount equal to at least 10 percent of the amount of withholding tax credit dollars received by the pilot project city, then the pilot project city shall not be required to make a contribution to the local match.

d. A pilot project city's contribution, if any, to the local match may include the dollar value of any new tax abatement provided by the city to the business for new construction. For purposes of this paragraph, new construction includes building additions, remodeling, renovations, and updates.

71.4(8) *Termination of a withholding agreement.* Following the termination of a withholding agreement, the employer credits shall cease and any funds received by the pilot project city after the agreement has been terminated shall be remitted to the state treasurer to be deposited in the general fund of the state. The pilot project city shall notify the department of revenue within 30 days of the termination of the withholding agreement. If the authority, following an 18-month performance period beginning on the date the withholding agreement is approved by the board, determines that the employer does not meet the requirements of the withholding agreement relating to retaining jobs, if applicable, the agreement shall be terminated by the authority and the pilot project city and any withholding credits for the employer shall cease. If the authority, following a three-year performance period beginning on the date the withholding agreement is approved by the board, determines that the employer has not met or is incapable of meeting the requirements of the withholding agreement relating to creating jobs, if applicable, or the requirement of the withholding agreement relating to the qualifying investment prior to the end of the withholding agreement, the authority may reduce the future benefits to the employer under the agreement or negotiate with the other parties to terminate the agreement early.

71.4(9) Participation in other programs. An employer may participate in the Iowa industrial new jobs training program under Iowa Code section 260E.5 or may claim a supplemental withholding credit under Iowa Code section 15E.197, at the same time the employer is participating in the targeted jobs withholding tax credit program. The withholding credit under section 260E.5 and the supplemental withholding credit under section 15E.197 shall be collected and disbursed prior to the collection and disbursement of the withholding credit under the targeted jobs withholding tax credit program.

[ARC 7561B, IAB 2/11/09, effective 3/18/09 (See Delay note at end of chapter); ARC 7847B, IAB 6/17/09, effective 5/21/09; ARC 7848B, IAB 6/17/09, effective 7/1/09; ARC 8147B, IAB 9/23/09, effective 10/28/09; ARC 1373C, IAB 3/19/14, effective 2/24/14; ARC 4512C, IAB 6/19/19, effective 7/24/19; ARC 4990C, IAB 3/11/20, effective 4/15/20]

261—71.5(403) Project approval.

71.5(1) Request for board approval of withholding agreement.

a. Request for approval form. Prior to entering into a withholding agreement with an employer and the authority, a pilot project city must receive approval from the board, on behalf of the authority. The authority shall develop a standardized form to be used by pilot project cities to request board approval of a proposed withholding agreement. To request board approval of a proposed withholding agreement, a pilot project city shall submit the standardized form to the authority with the following information:

(1) A general description of the project, including how the pilot project city will utilize withholding funds generated by the project.

(2) Base employment of the number of full-time equivalent positions at a business as established by the authority and the pilot project city, using the business's payroll records, as of the date that a business files an application with a pilot project city for financial assistance under the program.

(3) Information regarding the number of targeted jobs in the project, the wages of the targeted jobs, and the types of jobs created by the project.

(4) A budget for the project, showing the total project cost, the amount of local matching funds committed to the project, and the amount of withholding funds the pilot project city will receive from the project.

(5) A letter or resolution of support from the local government showing support for the project.

b. Timing of submittal. Requests for board approval of a proposed withholding agreement may be submitted at any time. The authority will review requests for approval of a proposed withholding agreement in as timely a manner as possible.

c. Board action on requests for approval. The board, on behalf of the authority, may approve or deny a withholding agreement according to the provisions of this chapter. Each withholding agreement and the total amount of the withholding credits allowed under the withholding agreement shall be approved by the board after taking into account the incentives or assistance received by or to be received by the employer under other economic development programs. The board shall only deny a withholding agreement if the agreement fails to meet the requirements as stated in subrule 71.4(2) and paragraph 71.6(1) "b" or the local match requirement as stated in subrule 71.4(7) or if an employer is not in good standing as to prior or existing agreements with the authority. The board shall have the authority to negotiate a withholding agreement and may suggest changes to any of the terms of the withholding agreement, including the total amount of withholding credits. A pilot project city and employer will be notified in writing of the board's decision regarding the proposed withholding agreement.

71.5(2) Certification to the department of revenue.

a. The employer shall certify to the department of revenue that the targeted jobs withholding tax credit is in accordance with the withholding agreement and shall provide other information the department of revenue may require.

b. A pilot project city shall certify to the department of revenue the amount of the targeted jobs withholding tax credit an employer has remitted to the city and shall provide other information the department of revenue may require.

c. Notice of any withholding agreement shall be provided promptly to the department of revenue following its execution between a pilot project city and an employer.

[ARC 7561B, IAB 2/11/09, effective 3/18/09 (See Delay note at end of chapter); ARC 7847B, IAB 6/17/09, effective 5/21/09; ARC 7848B, IAB 6/17/09, effective 7/1/09; ARC 8147B, IAB 9/23/09, effective 10/28/09; ARC 1373C, IAB 3/19/14, effective 2/24/14]

261—71.6(403) Reporting requirements.**71.6(1) Required reports.**

a. At the time the pilot project city submits its budget to the department of management, the pilot project city shall submit to the department of management and the authority a description of the activities involving the use of withholding agreements. The description shall include, but not be limited to, the following:

(1) The total number of targeted jobs associated with withholding agreements and the wages of those targeted jobs.

(2) A breakdown of the number of targeted jobs that are associated with Iowa business expansions or retentions within the city limits of the pilot project city and the number of targeted jobs resulting from out-of-state businesses moving to or expanding in Iowa.

(3) The number of withholding agreements and the amount of withholding credits associated with those agreements.

(4) The types of businesses that entered into withholding agreements with the city and the types of businesses that declined the city's proposal to enter into a withholding agreement with the city.

b. Pursuant to rules adopted by the authority, the pilot project city shall provide to the authority information documenting the compliance of each employer with each requirement of the withholding agreement, including but not limited to the number of jobs created or retained, the wages associated with the targeted jobs, and the amount of investment made by the employer. The pilot project city shall provide this information annually by September 1. The authority shall, in response to receiving such information from the pilot project city, assess the level of compliance by each employer and provide to the pilot project city recommendations for either maintaining employer compliance with the withholding agreement or terminating the agreement for noncompliance under subrule 71.4(8). The authority shall also provide each such assessment and recommendation report to the department of revenue.

c. The employer, in conjunction with the pilot project city, shall provide information documenting the total amount of payments and receipts from the withholding project fund under the withholding agreement, including all agreements between the pilot project city and the employer to suspend, abate, exempt, rebate, refund, or reimburse property taxes, to provide a grant for property taxes, to provide a grant not related to property taxes, or to make a direct payment of taxes. The employer and the pilot project city shall submit this information to the authority annually by September 1 covering the prior fiscal year (July 1 to June 30). The authority shall verify the information provided and determine whether the pilot project city and the employer are in compliance with Iowa Code section 403.19A and this chapter. The authority will verify job creation or retention using the method described in 261—Chapter 188.

d. The authority may request additional reports from pilot project cities as necessary to determine the status of the targeted jobs withholding tax credit program.

e. The authority shall make, at minimum, an annual on-site monitoring visit to each pilot project city to verify the documented information. The pilot project city shall provide the following:

(1) Payroll records that correspond to the quarterly report provided by the pilot project city for the department of revenue;

(2) Information substantiating the total amount of qualifying investment made in the project;

(3) Information substantiating the total amount of local financial support made in the project;

(4) Payments and receipts as described in paragraph 71.6(1)“c.”

71.6(2) Annual report. As required by Iowa Code section 15.104(9)“k,” the authority shall include in its annual report information about the targeted jobs withholding tax credit program. This report is due on January 31 of each year.

[ARC 7561B, IAB 2/11/09, effective 3/18/09 (See Delay note at end of chapter); ARC 7848B, IAB 6/17/09, effective 7/1/09; ARC 8147B, IAB 9/23/09, effective 10/28/09; ARC 1373C, IAB 3/19/14, effective 2/24/14]

261—71.7(403) Applicability.

71.7(1) Except as provided in rule 261—71.2(403), this chapter applies to withholding agreements entered into on or after July 1, 2013, in accordance with 2013 Iowa Code section 403.19A as amended

by 2013 Iowa Acts, Senate File 433. Withholding agreements entered into prior to July 1, 2013, shall be governed by this chapter as it existed prior to the enactment of 2013 Iowa Acts, Senate File 433.

71.7(2) Paragraph 71.6(1) “b” applies to withholding agreements entered into prior to July 1, 2013, or entered into on or after July 1, 2013.

71.7(3) The authority will work with pilot project cities and businesses to amend existing agreements to reflect the requirements of subrule 71.7(2) of this rule.

[ARC 1373C, IAB 3/19/14, effective 2/24/14]

These rules are intended to implement Iowa Code section 403.19A.

[Filed emergency 7/19/06—published 8/16/06, effective 7/19/06]

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[Editorial change: IAC Supplement 3/25/09]

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[Filed Emergency ARC 7848B, IAB 6/17/09, effective 7/1/09]

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[Filed Emergency After Notice ARC 1373C (Notice ARC 1248C, IAB 12/25/13), IAB 3/19/14, effective 2/24/14]

[Filed ARC 4512C (Notice ARC 4355C, IAB 3/27/19), IAB 6/19/19, effective 7/24/19]

[Filed ARC 4990C (Notice ARC 4737C, IAB 11/6/19), IAB 3/11/20, effective 4/15/20]

¹ The March 18, 2009, effective date of **ARC 7561B** was delayed 70 days by the Administrative Rules Review Committee at its meeting held March 6, 2009.

CHAPTER 81
RENEWABLE CHEMICAL PRODUCTION TAX CREDIT PROGRAM

261—81.1(15) Purpose. The purpose of this chapter is to encourage development of the renewable chemicals industry and stimulate job growth using the renewable chemical production tax credit program to incentivize new and existing businesses to produce high-value renewable chemicals in Iowa from biomass feedstock.

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.2(15) Definitions. As used in this chapter, the following definitions shall apply:

“*Authority*” means the economic development authority created in Iowa Code section 15.105.

“*Authority’s website*” means the information and related content found at www.iowaeconomicdevelopment.com and may include integrated content at affiliate sites.

“*Biobased content percentage*” means, with respect to any renewable chemical, the amount, expressed as a percentage, of renewable organic material present as determined by testing representative samples using the American Society for Testing and Materials standard D6866.

“*Biomass feedstock*” means sugar, polysaccharide, crude glycerin, lignin, fat, grease, or oil derived from a plant or animal, or a protein capable of being converted to a building block chemical by means of a biological or chemical conversion process.

“*Board*” means the members of the economic development authority board appointed by the governor and in whom the powers of the authority are vested pursuant to Iowa Code section 15.105.

“*Building block chemical*” means a molecule converted from biomass feedstock as a first product or a secondarily derived product that can be further refined into a higher-value chemical, material, or consumer product. “Building block chemical” includes but is not limited to high-purity glycerol, oleic acid, lauric acid, methanoic or formic acid, arabonic acid, erythronic acid, glyceric acid, glycolic acid, lactic acid, 3-hydroxypropionate, propionic acid, malonic acid, serine, succinic acid, fumaric acid, malic acid, aspartic acid, 3-hydroxybutyrolactone, acetoin, threonine, itaconic acid, furfural, levulinic acid, glutamic acid, xylonic acid, xylaric acid, xylitol, arabitol, citric acid, aconitic acid, 5-hydroxymethylfurfural, lysine, gluconic acid, glucaric acid, sorbitol, gallic acid, ferulic acid, nonfuel butanol, nonfuel ethanol, benzene, toluene, xylene, ethylbenzene, butanoic acid, hexanoic acid, octanoic acid, pentanoic acid, and heptanoic acid, or such additional molecules as may be included by the authority following the procedure in rule 261—81.8(15).

“*Crude glycerin*” means glycerin with a purity level below 95 percent.

“*Director*” means the director of the economic development authority or the director’s designee.

“*Eligible business*” means a business meeting the requirements of rule 261—81.3(15).

“*Food additive*” means a building block chemical that is not primarily consumed as food but which, when combined with other components, improves the taste, appearance, odor, texture, or nutritional content of food. The authority, in its discretion, shall determine whether or not a building block chemical is primarily consumed as food.

“*High-purity glycerol*” means glycerol with a purity level of 95 percent or higher.

“*Pre-eligibility production threshold*” means, with respect to each eligible business, the number of pounds of renewable chemicals produced, if any, by an eligible business during the calendar year prior to the calendar year in which the business first qualified as an eligible business pursuant to rule 261—81.3(15).

“*Production year*” means any calendar year after the year in which the eligible business’s pre-eligibility production threshold was established and in which the eligible business produces renewable chemicals.

“*Program*” means the renewable chemical production tax credit program administered pursuant to this chapter.

“*Renewable chemical*” means a building block chemical with a biobased content percentage of at least 50 percent. “Renewable chemical” does not include a chemical sold or used for the production of food, feed, or fuel. “Renewable chemical” includes cellulosic ethanol, starch ethanol, or other ethanol

derived from biomass feedstock, fatty acid methyl esters, or butanol, but only to the extent that such molecules are produced and sold for uses other than food, feed, or fuel. “Renewable chemical” also includes a building block chemical that can be a food additive as long as the building block chemical is not primarily consumed as food and is also sold for uses other than food. “Renewable chemical” also includes supplements, vitamins, nutraceuticals, and pharmaceuticals, but only to the extent that such molecules do not provide caloric value so as to be considered sustenance as food or feed.

“*Sugar*” means the organic compound glucose, fructose, xylose, arabinose, lactose, sucrose, starch, cellulose, or hemicellulose.

[ARC 3004C, IAB 3/29/17, effective 5/3/17; ARC 4307C, IAB 2/13/19, effective 3/20/19; ARC 4971C, IAB 3/11/20, effective 4/15/20]

261—81.3(15) Eligibility requirements. To be eligible to receive the renewable chemical production tax credit pursuant to the program, a business shall meet all of the following requirements:

81.3(1) *Physical location.* The business must have a facility that produces renewable chemicals and is physically located in the state of Iowa. If a business has facilities located in more than one state, only those renewable chemicals produced at facilities physically located in the state of Iowa may be counted for the purpose of calculating the tax credit under subrule 81.6(1).

81.3(2) *Operated for profit and under single management.* The business must be operated for profit and under single management. For purposes of this rule, “single management” means that if the same eligible business has an ownership or equity interest in multiple facilities at which renewable chemicals are produced, the facilities under common ownership will be considered a single eligible business for purposes of calculating the maximum tax credit amount under rule 261—81.6(15). In calculating the maximum tax credit amount under rule 261—81.6(15), only the pro rata share of each eligible business’s ownership in a facility will be attributed to that eligible business.

81.3(3) *Type of business.* The business may not be an entity providing professional services, health care services, or medical treatments or an entity engaged primarily in retail operations.

81.3(4) *Organization.* The business must have organized, expanded, or located in the state on or after April 6, 2016.

81.3(5) *Not reducing operations.* The business shall not be relocating or reducing operations as described in Iowa Code section 15.329(1) “b” and as determined under the discretion of the authority.

81.3(6) *Compliance.* The business must be in compliance with all agreements entered into under this program or other programs administered by the authority.

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.4(15) Application process and review.

81.4(1) An eligible business that produces a renewable chemical in this state from biomass feedstock during a calendar year may apply to the authority for the renewable chemical production tax credit.

81.4(2) The application shall be made to the authority in the manner prescribed by the authority. Information about the program and a link to the online application and instructions may be obtained by contacting the authority or by visiting the authority’s website:

Iowa Economic Development Authority
Business Development Division
200 East Grand Avenue
Des Moines, Iowa 50309
(515)725-3000
www.iowaeconomicdevelopment.com

81.4(3) The application shall be made to the authority during the calendar year following the calendar year in which the renewable chemicals were produced. For example, an eligible business may submit an application in calendar year 2018 to receive a tax credit based on renewable chemicals produced in calendar year 2017.

81.4(4) The application may be submitted to the authority electronically during the annual filing window. This filing window shall be from February 15 to March 15 of each calendar year. The authority

may adjust the annual filing window dates under extenuating circumstances and will notify affected parties of such circumstances.

81.4(5) The application shall include all of the following information:

- a.* The name of the qualifying building block chemical produced by the eligible business for which the business is claiming a tax credit.
- b.* The amount of renewable chemicals produced in the state from biomass feedstock by the eligible business during the calendar year, measured in pounds.
- c.* The amount of renewable chemicals produced in the state from biomass feedstock by the eligible business during the calendar year prior to the year in which the business first qualified as an eligible business under the program.
- d.* The city or county where the plant producing renewable chemicals is located.
- e.* The type of feedstock used to produce the renewable chemicals.
- f.* The date on which the eligible business organized, expanded or located in the state.
- g.* Any other information reasonably required by the authority in order to establish and verify eligibility under the program.

81.4(6) Applications will be reviewed by the authority on a first-come, first-served basis as described in subrule 81.6(5). Applications shall be date- and time-stamped by the authority in the order in which such applications are received. If the authority deems that additional information is needed before a determination of eligibility can be made, and the authority makes a written request for additional information from the applicant, the applicant must provide the requested information within 30 days of the date that the written request from the authority was made. If an applicant does not provide the requested information within 30 days, the applicant will be placed at the end of the queue of applications received. The authority shall review the queue of applications for eligibility and maintain a list of successful applicants as required by subrule 81.6(5).

81.4(7) The authority shall notify an applicant when the applicant has been placed on the list of successful applicants.

a. For applicants on the list for whom there are sufficient tax credits available in the aggregate cap for the fiscal year, the applicant must sign the agreement within 60 days of being notified of eligibility for the tax credit. Upon request by the applicant, the authority may extend the time period for signing the agreement by an additional 30 days.

b. For applicants on the wait list established in subrule 81.6(5), the authority shall notify the applicant of the applicant's status and position on the wait list.

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.5(15) Agreement.

81.5(1) *Agreement.* Before being issued a tax credit pursuant to this chapter, an eligible business shall enter into an agreement with the authority for the successful completion of all requirements of the program. As part of the agreement, and as a condition of receiving the tax credit, the eligible business shall agree to collect and provide any information reasonably required by the authority in order to allow the board to fulfill the board's reporting obligation under Iowa Code section 15.320.

81.5(2) *Fees.* The compliance cost fees authorized in rule 261—187.6(15) shall apply to all agreements entered into under this program and shall be collected by the authority in the same manner and to the same extent as described in that rule.

81.5(3) *Requirements.* An eligible business shall fulfill all the requirements of the program and the agreement before receiving a tax credit or entering into a subsequent agreement under this rule. The authority may decline to enter into a subsequent agreement under this rule or to issue a tax credit if an agreement is not successfully fulfilled.

81.5(4) *Issuance of credit.* Upon establishing that all requirements of the program and the agreement have been fulfilled, the authority shall issue a tax credit and related tax credit certificate to the eligible business stating the amount of renewable chemical production tax credit the eligible business may claim. The amount of the tax credit shall not exceed the amount allowable under rule 261—81.6(15).

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.6(15) Renewable chemical production tax credit.

81.6(1) Calculation of tax credit amount. An eligible business that has entered into an agreement pursuant to rule 261—81.5(15) may be issued a tax credit in an amount equal to the product of five cents multiplied by the number of pounds of renewable chemicals produced in this state from biomass feedstock by the eligible business during a given production year.

a. The maximum amount of tax credit that may be issued under the program to an eligible business for the production of renewable chemicals in a calendar year shall not exceed the following:

(1) In the case of an eligible business that has been in operation in the state for five years or less at the time of application, \$1 million.

(2) In the case of an eligible business that has been in operation in the state for more than five years at the time of application, \$500,000.

b. For purposes of this subrule, “operation” begins on the date the eligible business first began commercial production.

c. If an eligible business has been in operation in the state for five years or less at the time of application but is more than fifty percent owned by an eligible business that has been in operation in the state for more than five years, then that eligible business will be considered in operation in the state for more than five years pursuant to subparagraph 81.6(1) “a”(2).

81.6(2) Eligible business only. An eligible business shall not receive a tax credit for renewable chemicals produced before the date the business first qualified as an eligible business pursuant to rule 261—81.3(15).

81.6(3) Production above pre-eligibility production threshold. An eligible business shall only receive a tax credit for renewable chemicals produced in a calendar year to the extent such production exceeds the eligible business’s pre-eligibility production threshold as defined in rule 261—81.2(15). For example, if an eligible business produces 3 million pounds of renewable chemicals during calendar year 2016 and first becomes an eligible business under this chapter in calendar year 2017, the pre-eligibility production threshold for the business is 3 million pounds. If the same eligible business produces 10 million pounds of renewable chemicals during calendar year 2017, the eligible business may only receive a tax credit for the amount produced over the pre-eligibility production threshold, which in this example equals 7 million pounds.

81.6(4) Maximum number of credits. An eligible business shall not receive more than five tax credits under the program. Each tax credit must be applied for separately, and each application will be reviewed independently of past tax credits. Receipt of a tax credit in one year does not guarantee receipt of a tax credit in a subsequent year.

81.6(5) Tax credit wait list.

a. The authority shall issue tax credits under the program on a first-come, first-served basis until the maximum amount of tax credits allocated pursuant to Iowa Code section 15.119(2) “h” is reached for any given fiscal year. The authority shall maintain a list of successful applicants under the program, so that if the maximum aggregate amount of tax credits is reached in a given fiscal year, eligible businesses that successfully applied but for which tax credits were not issued shall be placed on a wait list in the order the eligible businesses applied and shall be given priority for receiving tax credits in succeeding fiscal years.

b. Placement on a wait list pursuant to this subrule shall not constitute a promise binding the state. The availability of a tax credit and issuance of a tax credit certificate pursuant to this rule in a future fiscal year is contingent upon the availability of tax credits in that particular fiscal year.

81.6(6) Termination and repayment. The failure by an eligible business in fulfilling any requirement of the program or any of the terms and obligations of an agreement entered into pursuant to this chapter may result in the reduction, termination, or rescission of the tax credits under Iowa Code section 15.319 and may subject the eligible business to the repayment or recapture of tax credits claimed. The repayment or recapture of tax credits pursuant to Iowa Code section 15.319(4) shall be accomplished in the same manner as provided in Iowa Code section 15.330(2).

81.6(7) Issuance of credit. The authority shall not issue a tax credit certificate prior to July 1, 2018.
[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.7(15) Claiming the tax credit.

81.7(1) *Maximum tax credit claimed.* An eligible business that has entered into an agreement pursuant to rule 261—81.5(15) may claim a tax credit in an amount equal to the product of five cents multiplied by the number of pounds of renewable chemicals produced in this state from biomass feedstock by the eligible business during a given production year within the limits set forth in rule 261—81.6(15). An eligible business may claim a tax credit for the production of more than one qualifying renewable chemical under this chapter, provided that the total tax credit claimed by the eligible business does not exceed the limits set forth in subrule 81.6(1). However, an eligible business shall not receive a tax credit for the production of a secondarily derived building block chemical if that chemical is also the subject of a credit at the time of production as a first product. The renewable chemical production tax credit shall not be available for any renewable chemical produced before the 2017 calendar year or after the 2026 calendar year.

81.7(2) *Who may claim the credit.* The tax credit shall be allowed against taxes imposed under Iowa Code chapter 422, division II or III. The tax credit shall be claimed for the tax year during which the eligible business was issued the tax credit. An individual may claim a tax credit under this chapter of a partnership, limited liability company, S corporation, cooperative organized under Iowa Code chapter 501 and filing as a partnership for federal tax purposes, estate, or trust electing to have income taxed directly to the individual. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the partnership, limited liability company, S corporation, cooperative, estate, or trust.

a. To claim a tax credit under this rule, a taxpayer shall include one or more tax credit certificates with the taxpayer's tax return.

b. The tax credit certificate shall contain the taxpayer's name, address, and tax identification number, the amount of the credit, the name of the eligible business, and any other information required by the department of revenue.

c. The tax credit certificate, unless rescinded by the authority, shall be accepted by the department of revenue as payment for taxes imposed pursuant to Iowa Code chapter 422, divisions II and III, subject to any conditions or restrictions placed by the authority upon the face of the tax credit certificate and subject to the limitations of the program.

81.7(3) *Refundability.* Any tax credit in excess of the tax liability is refundable. In lieu of claiming a refund, the taxpayer may elect to have the overpayment shown on the taxpayer's final, completed return credited to the tax liability for the following tax year.

81.7(4) *Transferability.* Tax credit certificates issued pursuant to this chapter shall not be transferred to any other person.

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.8(15) Process to add building block chemicals.

81.8(1) *General process.* The authority may add additional molecules to the definition of "building block chemical" in rule 261—81.2(15) pursuant to Iowa Code section 15.316. The authority may initiate the administrative rule-making process for the addition of such molecules to this chapter.

81.8(2) *Request to include additional molecules.* Any individual or business may request that an additional molecule be added to the definition of "building block chemical" by submitting a written request to the authority. Such requests shall be made in the form prescribed by the authority and shall be submitted to the authority during the filing windows prescribed by the authority. At a minimum, the authority shall accept requests between April 1 and May 1 of each calendar year and October 1 and November 1 of each calendar year. The authority may adjust these dates under extenuating circumstances and will notify affected parties of such circumstances.

81.8(3) *Consultation with experts.* Prior to initiating a rule making to add molecules to the definition of "building block chemical" in rule 261—81.2(15), the authority shall consult with appropriate experts from Iowa state university, including but not limited to the Iowa state university center for biorenewable chemicals. The authority shall conduct an initial staff review of any requests received by the authority pursuant to subrule 81.8(2). Following the initial staff review, the authority shall

consult with the experts at Iowa state university regarding the molecules that the authority believes are consistent with the definitions under this chapter. The experts at Iowa state university shall provide a written recommendation to the authority indicating which chemicals, in the experts' opinion, meet the definition of "building block chemical" consistent with this chapter.

81.8(4) *Initiation of rule-making proceedings.* Following the consultation and review process set forth in subrule 81.8(3), the authority may initiate the administrative rule-making process to amend the definition of "building block chemical" to add molecules which the authority, in the authority's sole discretion, finds to be consistent with the definitions in this chapter.

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

261—81.9(15) Additional information—confidentiality—annual report.

81.9(1) *Additional information.* The authority may at any time request additional information and documentation from an eligible business regarding the operations, job creation, and economic impact of the eligible business, and the authority may use the information in preparing and publishing any reports to be provided to the governor and the general assembly.

81.9(2) *Confidential information.* Except as provided in subrule 81.9(3), any information or record in the possession of the authority with respect to the program shall be presumed by the authority to be a trade secret protected under Iowa Code chapter 550 or common law and shall be kept confidential by the authority unless otherwise ordered by a court.

81.9(3) *Public information.* The identity of a tax credit recipient and the amount of the tax credit shall be considered public information under Iowa Code chapter 22.

[ARC 3004C, IAB 3/29/17, effective 5/3/17]

These rules are intended to implement Iowa Code sections 15.315 to 15.322.

[Filed ARC 3004C (Notice ARC 2867C, IAB 12/21/16), IAB 3/29/17, effective 5/3/17]

[Filed ARC 4307C (Notice ARC 4043C, IAB 10/10/18), IAB 2/13/19, effective 3/20/19]

[Filed ARC 4971C (Notice ARC 4669C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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[Ch 7, July 1973 IDR Supplement, renumbered as Ch 81]

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

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

PREAMBLE

This chapter applies to contested case proceedings conducted by or on behalf of the department. The definitions in rule 441—7.1(17A) apply to the rules in both Division I and Division II of Chapter 7. [ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.1(17A) Definitions.

“*Adverse benefit determination*” means any adverse action taken as to any individual’s benefits pursuant to an assistance program administered by the department or on the department’s behalf, excluding determinations related to requests for exceptions to policy.

“*Appeals section*” means the director’s designee who is charged with administering the department’s appeals.

“*Appellant*” means a person, including an authorized representative acting on the person’s behalf, seeking to appeal some action pursuant to this chapter.

“*Assistance program*” means a program administered by the department or on the department’s behalf through which qualifying individuals receive benefits or services. Assistance programs include, but are not necessarily limited to, food assistance, Medicaid, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, the family self-sufficiency grant, PROMISE JOBS, state supplementary assistance, the healthy and well kids in Iowa (hawki) program, foster care, adoption, and aftercare services.

“*Authorized representative*” means a person lawfully designated by an individual to act on the individual’s behalf or who has legal authority to act on behalf of the individual.

“*Contested case*” refers to an evidentiary hearing mandated by state or federal constitutional or statutory authority whereupon a presiding officer makes a determination pertaining to the relative rights and obligations of parties to an appeal under this chapter.

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

“*DIA*” means the Iowa department of inspections and appeals and may include presiding officers where appropriate.

“*Director*” means the director of the department or the director’s designee.

“*Enrollee*” means any applicant to or recipient of benefits or services pursuant to an assistance program.

“*Good cause*” means an intervening cause, not attributable to the negligence of a party, reasonably resulting in a delay or in attendance, for purposes of subrules 7.4(3) and 7.9(2).

“*Intentional program violation*” means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the Food and Nutrition Act of 2008, food assistance program regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of an electronic benefit transfer (EBT) card. An intentional program violation is determined through a food assistance administrative disqualification hearing. The hearing may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

“*Managed care organization*” or “*MCO*” has the meaning assigned to it in rule 441—73.1(249A) and includes prepaid ambulatory health plans.

“*Medicaid*” means Iowa’s medical assistance program administered under Iowa Code chapter 249A.

“*Party-in-interest*” refers to the party, including enrollees, whose rights or obligations are the subject of a contested case hearing under this chapter. Parties-in-interest may or may not be the appellant.

“*Presiding officer*” means an administrative law judge charged with the administration and adjudication of the contested case hearing process for a particular appeal.

“*Self-represented*” means representing oneself without an attorney.
 [ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.2(17A) Governing law and regulations. In the absence of an applicable rule in this chapter, the DIA rules found at 481—Chapter 10 govern department appeals. Notwithstanding the foregoing and the rules contained in this chapter, to the extent that federal or state law (including regulations and rules) related to a specific program is more specific than or contradicts these rules or the applicable DIA rules, the program-specific federal or state law shall control. For example, food assistance appeals shall be conducted in accordance with 7 CFR 273.15 and 7 CFR 273.16, and medical assistance appeals shall be conducted in accordance with 42 CFR Part 431, subpart E, and Part 438, subpart F.
 [ARC 4972C, IAB 3/11/20, effective 4/15/20]

DIVISION I
 GENERAL APPEALS PROCESS

441—7.3(17A) When a contested case hearing will be granted.

7.3(1) Requirements. A person shall be granted a contested case hearing if the party-in-interest fulfills all of the following requirements:

- a. The party-in-interest is entitled to a contested case hearing;
- b. The party-in-interest has an ongoing, specific and personal interest in the outcome of the contested case hearing; and
- c. The party-in-interest meets all of the other requirements contained in these rules.

7.3(2) Contractual rights not subject to contested case hearing. Unless otherwise provided by law, when an appellant seeks a contested case hearing of an issue predicated upon or governed by the terms of a contract between appellant and another party, including the department, a contested case hearing shall not be provided.

7.3(3) Change in law. A contested case hearing shall not be granted when the sole issue raised is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries to an assistance program.

7.3(4) Competitive procurement bid appeals. Competitive procurement bid appeals shall be adjudicated pursuant to Division II of this chapter.
 [ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.4(17A) Initiating an appeal.

7.4(1) Exhaustion of remedies. An appellant shall only be granted a contested case hearing if the appellant has exhausted all other appeal remedies available to the party-in-interest. An appellant should refer to program-specific provisions for the appropriate procedures applicable to specific programs.

7.4(2) Medicaid managed care enrollees exhaustion of remedies.

a. A Medicaid managed care enrollee shall be granted a contested case hearing only if the enrollee has either received a decision from a managed care organization in the time and manner required by rule 441—73.12(249A) or has been deemed to have exhausted the managed care organization appeals under paragraph 7.4(2)“b.”

b. If a Medicaid enrollee’s managed care organization fails to provide a decision in the time and manner required by rule 441—73.12(249A), the enrollee shall be deemed to have exhausted the managed care organization’s appeals process and may initiate a contested case hearing.

7.4(3) Time to appeal. For a contested case hearing to be granted, the following timelines must be met:

a. *Food assistance, Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, family planning program and autism support program.* For appeals pertaining to food assistance, Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, the family planning program or the autism support program, the appellant must appeal on or before the ninetieth day following the date of notice of an adverse benefit determination.

b. Managed care organization medical coverage. For appeals pertaining to medical services coverage under Medicaid managed care, the appellant must appeal on or before the one hundred twentieth day following the date of exhaustion, actual or deemed, of the managed care organization appeal process outlined in rule 441—73.12(249A).

c. Tax offsets. Except for counties appealing an offset under 441—Chapter 14, for appeals of state or federal tax offsets, the appellant must appeal on or before the fifteenth day following the date of notice of the action. For counties appealing a debtor offset under 441—Chapter 14, the county must appeal on or before the thirtieth day following the date of notice of the offset.

d. Iowa individual disaster assistance program. For appeals pertaining to the Iowa individual disaster assistance program, the appellant must appeal on or before the fifteenth day following the date of the department's reconsideration decision, pursuant to 441—subrule 58.7(1).

e. Iowa disaster case management program. For appeals pertaining to the Iowa disaster case management program, the appellant must appeal on or before the fifteenth day following the date of the department's reconsideration decision, pursuant to 441—subrule 58.7(1).

f. Dependent adult abuse. For appeals regarding dependent adult abuse, the appellant must appeal within six months of the date of notice of the action as provided in Iowa Code section 235B.10.

g. Child abuse. For appeals regarding child abuse, the person alleged responsible for the abuse must appeal on or before the ninetieth day following the date of notice of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the appeal on or before the tenth day following the date of notice of the right to intervene.

h. Sex offender risk assessment. For appeals regarding a sex offender risk assessment, the appellant must appeal in writing on or before the fourteenth day following the date of notice.

i. Assistance program overpayments. For appeals pertaining to the family investment program, refugee cash assistance, PROMISE JOBS, child care assistance, medical assistance, healthy and well kids in Iowa (hawki), family planning program or food assistance overpayments, the party-in-interest's right to appeal the existence, computation and amount of the overissuance or overpayment begins when the department sends the first notice informing the party-in-interest of the overissuance or overpayment.

j. All other appeals. For all other appeals, and unless federal or state law provides otherwise elsewhere, the appellant must appeal on or before the thirtieth day following the date of notice of the action being appealed. If such an appeal is made more than 30 days, but less than 90 days, of the date of notice, the director or director's designee may, at the director's or designee's sole discretion, allow a contested case hearing if the delay was for good cause, substantiated by the appellant.

7.4(4) Written and oral notification. The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

a. Written notification of the following shall be given at the time of application and at the time of any agency action affecting the claim for assistance.

(1) The right to request a hearing.

(2) The procedure for requesting a hearing.

(3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.

b. Written notification shall be given on the application form and all notices of decision.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.5(17A) How to request an appeal.

7.5(1) Ways to request a hearing. An appellant may request a contested case hearing:

a. Via the department's website,

b. By telephone, except as specified in subrule 7.5(4),

c. By mail,

d. In person, except as specified in subrule 7.5(4), or

e. Through other commonly available electronic means (such as email or facsimile).

7.5(2) *Hearing request.* The request for a contested case hearing must be sufficiently detailed so that the department can reasonably understand the action being appealed. The department may request additional information to determine the scope of the appeal. The department may deny if there is not sufficient information to determine the action being appealed.

7.5(3) *Filing date.* The date of filing for appeal requests sent by regular mail shall be the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the agency. The date of filing for appeal requests sent electronically shall be determined by the date on which the electronic submission was completed.

7.5(4) *Appeals that must be filed in writing.* Appeal requests pertaining to foster care, adoption, state supplementary assistance, the autism support program, the Iowa individual disaster assistance program, the Iowa disaster case management program, sex offender risk assessment, record check evaluation, child care registered or nonregistered homes, child abuse, dependent adult abuse or child support must be made in writing.

7.5(5) *Department's responsibilities.* Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

a. Within one working day of receipt of an appeal request, forward Form 470-0487 or 470-0487(S), Appeal and Request for Hearing; the written appeal; the postmarked envelope, if there is one; and a copy of the notification of the proposed adverse action to the appeals section.

b. Within ten days of the receipt of the appeal, forward a summary and supporting documentation of the worker's or agent's factual basis for the proposed action to the appeals section. When practicable, the summary may also include suggested relevant legal authorities.

c. Copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal are to be provided to the appellant at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.6(17A) Prehearing procedures.

7.6(1) *Acknowledgment of appeal.* When the appeals section receives a request for appeal, it shall send acknowledgment of the receipt of the appeal to the parties to the appeal. For appeals regarding child abuse, all subjects other than the person alleged responsible (party-in-interest) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

7.6(2) *Acceptance or denial of appeal.* The appeals section will determine with reasonable promptness whether the party-in-interest is entitled to a contested case hearing under rule 441—7.3(17A). If a request is accepted, the appeals section will certify the appeal to DIA and designate the issues on appeal pursuant to subrule 7.6(3). If a request for a contested case hearing is denied, the appeals section will provide written notice of and the reasons for the denial. On or before the thirtieth day following the denial, the individual requesting the appeal may provide additional information related to the individual's asserted right to a contested case hearing and request reconsideration of the denial.

7.6(3) *Designation of issues for appeal.*

a. Initial designation. After determining that the party-in-interest is entitled to a contested case hearing, the appeals section will designate the issues to be decided at the contested case hearing. The issues identified may include all issues raised by the appellant and may also include additional issues identified by the appeals section. The issues designated shall be certified to DIA and be identified in the notice of hearing issued pursuant to subrule 7.6(5).

b. Additional designation of issues. If any party believes additional issues should be designated, on or before the tenth day following the date of the notice of hearing, the party shall identify those additional issues. The presiding officer shall determine whether all issues have properly been preserved. If the hearing is within ten days of the date of the notice of hearing, the party shall identify any additional issues at the hearing.

7.6(4) *Group hearings regarding medical assistance.* The appeals section may respond to a series of related, individual requests for hearings regarding medical assistance by consolidating individual

hearings into a single group hearing where the sole issue is based on state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

7.6(5) Notice of hearing.

a. Issuance of hearing notice. Except as provided in paragraph 7.6(5) “b,” DIA shall send notice to the parties of the appeal at least ten calendar days in advance of the hearing setting forth the date, time, method, and place of the hearing; that evidence may be presented orally or documented to establish pertinent facts; that the parties may bring and question witnesses and refute testimony; and that the parties may be represented by others, including an attorney, at the parties’ own cost and as subject to state and federal law. Notice shall be mailed by first-class mail, postage prepaid, and addressed to the appellant at the appellant’s last-known address.

b. Intentional program violation hearing notices. DIA shall send notices of hearing regarding alleged intentional program violations at least 30 days in advance of the hearing date. The notices under this paragraph shall otherwise comply with the requirements of paragraph 7.6(5) “a.”

7.6(6) Appellant’s right to department’s case file. Prior to and during the contested case hearing, the department must provide enrollees or their authorized representative with the opportunity to examine the content of the appellant’s case file, if any, and all documents and records to be used by the department at the hearing.

7.6(7) Informal conference. The purpose of an informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action or position, and to provide an opportunity for the appellant to examine the contents of the case record.

a. When requested by the appellant, an informal conference with a representative of the department or one of its contracted partners, including a managed care organization, shall be held as soon as possible after the appeal has been filed. An appellant’s representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

b. An informal conference need not be requested for the appellant to examine the contents of the case record.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.7(17A) Timelines for contested case hearings.

7.7(1) Medical assistance. In cases involving the determination of medical assistance, the contested case hearing shall be held within a time frame such that the final administrative action is timely pursuant to 42 CFR 431.244(f).

7.7(2) Community spouse resource allowance. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

7.7(3) Sex offender risk assessment. In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.8(17A) Contested case hearing procedures.

7.8(1) Method. Contested case hearings may be conducted via telephone or videoconference. Upon request of a party to the appeal or order of the presiding officer, the contested case hearing shall be conducted in person.

7.8(2) Evidence.

a. The parties to a contested case hearing shall be permitted to:

- (1) Bring witnesses,
- (2) Submit competent evidence to establish all pertinent facts and circumstances,
- (3) Present arguments without undue interference,
- (4) Question or refute any testimony or evidence, including through cross-examination, and
- (5) Respond to evidence and arguments on all issues.

b. Evidence shall be received or excluded as provided in Iowa Code section 17A.14.

7.8(3) *Right to counsel.* Parties to an appeal shall be permitted to be represented by counsel at the parties' own expense.

7.8(4) *Self-represented appellants.* The presiding officer shall, at the officer's discretion, provide reasonable assistance to self-represented appellants. The presiding officer must, however, ensure that such assistance does not impact the independence and fairness of the contested case hearing process.

7.8(5) *Closed to public.* Contested case hearings are closed to the public, and unless otherwise provided by state or federal law, only the parties, their representatives, permissible intervenors, and witnesses may be present for a contested case hearing in the absence of mutual agreement of the parties.

7.8(6) *Administration of appeals.* Except as otherwise provided in this chapter or other applicable federal or state law, discretion in the conduct and administration of appeals is vested in the contested case hearing presiding officer.

7.8(7) *Contested cases with no factual dispute.* If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.9(17A) Miscellaneous rules governing contested case hearings.

7.9(1) *Ex parte communication.* Ex parte communications between the presiding officer and person or party in connection with any issue of fact or law in the contested case proceeding is prohibited except as permitted by Iowa Code section 17A.17. All of the provisions of Iowa Code section 17A.17 apply.

7.9(2) *Default.* If a party fails to appear at a scheduled hearing or prehearing conference without good cause as determined by the presiding officer, the party's appeals may be denied and dismissed or may be heard and ruled upon, consistent with Iowa Code section 17A.12. Defaulting parties may file a timely motion to vacate, which shall be granted if the presiding officer determines good cause has been shown.

7.9(3) *Withdrawal.* An appellant may submit a withdrawal of a fair hearing request at any time prior to hearing through any of the methods identified in subrule 7.5(1), except for programs listed in subrule 7.5(4). For programs listed in subrule 7.5(4), a written request may be submitted via the department's website, by mail, in person, or through other commonly available electronic means (such as email or facsimile). Unless otherwise provided, a withdrawal shall be with prejudice.

7.9(4) *Medical assessment.* For Medicaid enrollees engaged in an appeal involving medical issues, the department may request, at the department's own expense, that the appellant submit to an appropriate medical assessment. The presiding officer shall order such assessment upon sufficient showing of necessity.

7.9(5) *Interpreters.* The department shall provide translation and interpretation services to appellants not fluent in English. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when an appellant is illiterate or semiliterate, the presiding officer shall advise the appellant of the appellant's rights to the satisfaction of the appellant's understanding.

7.9(6) *Persons living with disabilities.* Persons living with disabilities shall be provided assistance through the use of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.10(17A) Proposed decision.

7.10(1) *Contents.* The presiding officer shall issue a written proposed decision to all parties clearly identifying the issues on appeal, holding, findings of fact, conclusions of law, and order. The findings of fact shall cite and be based exclusively on the record as defined by Iowa Code section 17A.12(6). The conclusions of law shall be limited to the contested issues of fact, policy or law and shall identify the specific provisions of law that support the ultimate conclusion.

7.10(2) Access to record. After receiving the proposed decision, appellants shall be given reasonable access to the record at a convenient place and time.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.11(17A) Director’s review.

7.11(1) Time. Parties, including the department, may appeal the proposed decision to the director.

a. A request for director’s review shall be in writing and postmarked or received within ten calendar days of the date on which the proposed decision was issued, except as provided for under paragraph 7.11(1) “*b.*” A request for director’s review may be accompanied by a brief written summary of the arguments in favor of director’s review.

b. A managed care organization appealing a proposed decision reversing an adverse benefit determination shall request director’s review within 72 hours from the date it received notice of the proposed decision.

7.11(2) Grant or denial of review. The department has full discretion to grant or deny a request for review. In addition, the director may initiate review of a proposed decision on the director’s own motion at any time on or before the tenth day following the issuance of the proposed decision.

When the department grants a request for director’s review, the appeals section shall notify the parties to the appeal of the review request and enclose a copy of the request. All other parties shall have ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

7.11(3) Cross-appeal. When a party requests director’s review in accordance with subrule 7.11(1), the remaining parties shall have ten calendar days from that date to submit cross-requests for director’s review. The party originally seeking director’s review shall have ten calendar days from the date of the cross-request for director’s review to submit further written arguments or objections for consideration upon review.

7.11(4) Limited record. Director’s review shall be limited to the issues and record before the contested case hearing presiding officer.

7.11(5) Oral arguments. Upon specific request, the director may, at the director’s discretion, permit parties to present oral arguments with the parties’ requests for director’s review.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.12(17A) Final decisions.

7.12(1) No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the presiding officer’s proposed decision becomes the final decision of the agency.

7.12(2) Timelines.

a. The department or director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the department or director will issue a final decision on or before the ninetieth day from the date the department receives an appeal request.

b. Except as otherwise provided by state or federal law, the time frames for a final decision provided under this rule may be tolled when:

- (1) The appellant requests a delay;
- (2) The appellant fails to take a required action; or
- (3) There is an administrative or other emergency beyond the department’s control.

c. DIA shall document in the record the reasons for any delay and the requesting party.

7.12(3) Written notice of final decision. The parties to the appeal shall be provided written notice of the department’s final decision. The department shall also notify the appellant of the appellant’s right to seek judicial review, where applicable.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.13(17A) Expedited review.

7.13(1) Expedited review criteria. Appellants to a medical assistance appeal may, at any time, file with the department a request for expedited review of the appeal. Expedited review shall be granted when

the department determines, or a provider acting on behalf or in support of an appellant indicates, that taking the time for a standard resolution could seriously jeopardize the party-in-interest's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

7.13(2) *Managed care expedited proceedings.*

a. If the appellant is granted an expedited review pursuant to subrule 73.12(2), all subsequent proceedings shall also be expedited without an additional request if the appeal request indicates that the managed care organization appeal was expedited and provides the basis for expedited relief.

b. When review is expedited pursuant to paragraph 7.13(2) "a," the presiding officer shall issue a proposed decision as expeditiously as the enrollee's health condition requires, but no later than three working days after the department receives from the managed care organization the case file and information for any appeal of a denial of a service that, as indicated by the managed care organization:

(1) Meets the criteria for expedited resolution but was not resolved within the time frame for expedited resolution; or

(2) Was resolved within the time frame for expedited resolution but reached a decision wholly or partially adverse to the enrollee.

7.13(3) *Medicaid eligibility, nursing facility transfers or discharges, or preadmission and annual resident review expedited proceedings.* For expedited appeals related to Medicaid eligibility, nursing facility transfers or discharges, or preadmission and annual resident review requirements, the presiding officer shall issue a proposed decision as expeditiously as possible, but no later than seven working days after the department receives a request for expedited fair hearing.

7.13(4) *Medicaid-covered benefits or services expedited proceedings.* For expedited appeals related to Medicaid-covered benefits or services, the presiding officer shall issue a proposed decision as expeditiously as possible, but no later than provided in paragraph 7.13(2) "b."

7.13(5) *Final decision for expedited proceeding.* The department shall issue its final decision in accordance with this rule, except as provided by subrule 7.12(2).

7.13(6) *Notification if expedited relief is granted or denied.* The department shall notify the appellant as expeditiously as possible whether the request for expedited relief is granted or denied. Such notice must be provided orally or through electronic means to the extent consistent with federal and state law. If oral notice is provided, the department shall follow up with written notice, which may be through electronic means to the extent consistent with federal and state law.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.14(17A) Effect.

7.14(1) If the contested case hearing presiding officer's proposed decision is favorable to an enrollee in a Medicaid appeal, the department must promptly make corrective payments retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility. If the presiding officer reverses a decision of a managed care organization to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date the managed care organization receives notice reversing the determination.

7.14(2) Unless there is contravening federal or state law, all final decisions shall be put into effect within seven days of the issuance of the final decision.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.15(17A) Calculating time. In computing any time period specified in this chapter, the period:

1. Excludes the day of the event that triggers the period;
2. Includes every day of the time period (including Saturdays, Sundays, and holidays on which the department is closed); and
3. Includes the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues to run until the end of the next day that is not a Saturday, Sunday, or legal holiday.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.16(17A) Authorized representatives.

7.16(1) Regulations. The provisions of this rule only apply to the extent the standards expressed in this rule are not in conflict with other state or federal law.

7.16(2) Designation of authority. Legally recognized delegations of authority, such as guardianships, applicable designations of power of attorney, or similar designations, shall be sufficient for a delegate to serve as authorized representative under this chapter. A person who is not designated a legally recognized delegation of authority but who otherwise seeks to act as an authorized representative for an individual in an appeal under this chapter shall provide a written, signed designation of authority to the department with the request for appeal. The designation must provide the scope of the representation, applicable waivers for the release of confidential information, and any temporal or other limitations on the scope of representation. An authorized representative of a party-in-interest only represents the party-in-interest and has no independent right to appeal by virtue of the authorized representative's representation.

7.16(3) Written designation. For persons seeking to act as authorized representative of a party-in-interest in a Medicaid managed care appeal, the authorized representative's written designation of authority pursuant to subrule 7.16(2) shall be Form 470-5526, Authorized Representative for Managed Care Appeals.

7.16(4) Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this chapter shall enter an appropriate written appearance identifying the legal counsel.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.17(17A) Continuation and reinstatement of benefits.

7.17(1) Programs for which no federal or state law applies. For all assistance programs for which there is no contravening federal or state law, benefits or services shall not be suspended, reduced, restricted, or discontinued, nor shall a license, registration, certification, approval, or accreditation be revoked or other adverse action taken pending a final decision when:

- a. An appeal is filed before the effective date of the intended action; or
- b. The appellant requests a hearing within ten days of receipt of a notice to suspend, reduce, restrict, or discontinue benefits or services. The date on which the notice is received is considered to be five days after the date on the notice, unless the appellant shows the notice was not received within the five-day period.

7.17(2) Sole issue is state or federal law or policy. Benefits or services continued pursuant to subrule 7.17(1) may be suspended, reduced, restricted, or discontinued if the presiding officer determines at the contested case hearing that the sole issue is one of state or federal law or policy and the department has notified the enrollee in writing that services are to be suspended, reduced, restricted, or discontinued pending the proposed decision.

7.17(3) Recoup cost of services or benefits. The department or managed care organization may recoup the cost of benefits or services provided pursuant to this chapter if the adverse action appealed from is affirmed, consistent with state and federal law.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.18(17A) Emergency adjudicative proceedings.

7.18(1) Necessary emergency action. When and to the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with state and federal law, a contested case hearing presiding officer may issue a written order to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order. In determining the necessity of such an action, the presiding officer shall consider factors including, but not limited to, the following:

- a. Whether there has been sufficient investigation and evidentiary support to ensure the order is proceeding based on reliable information;
- b. Whether the specific circumstances giving rise to the potential order have been specifically identified and determined to be continuing;

c. Whether the person who is required to comply with the emergency adjudicative order may continue to engage in other activities without risk of immediate danger to the public health, safety, or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and

e. Whether the specific action contemplated is necessary to avoid the immediate danger.

7.18(2) Issuance of order. An emergency adjudicative order shall contain, or shall be expeditiously followed by, a written analysis, including findings of fact, conclusions of law, and policy reasons to justify the order. The agency shall provide written notice that best ensures prompt, reliable delivery. Such order shall be immediately delivered to the persons required to comply with the order.

7.18(3) Completion of proceedings. Upon issuance of an order under this rule, the department shall proceed as quickly as reasonably practicable to complete any proceedings that would be required if the matter did not involve an immediate danger. An order issued under this rule shall include notice of the date on which proceedings under this chapter are to be completed. After issuance of an order under this rule, continuance of further proceedings under this chapter shall only be granted in compelling circumstances upon application in writing. Before issuing an emergency adjudicative order, the presiding officer shall consider factors including, but not limited to, the following:

a. Whether there has been sufficient investigation and evidentiary support to ensure the order is proceeding based on reliable information;

b. Whether the specific circumstances giving rise to the potential order have been specifically identified and determined to be continuing;

c. Whether the person who is required to comply with the emergency adjudicative order may continue to engage in other activities without risk of immediate danger to the public health, safety, or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety, or welfare; and

e. Whether the specific action contemplated is necessary to avoid the immediate danger.

[ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.19 to 7.40 Reserved.

DIVISION II
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

441—7.41(17A) Scope, bidder and applicability. The rules in Division II apply to appeals based on the department's competitive procurement bid process. A bidder is an entity that submits a proposal in response to a solicitation issued through the department of human services' competitive procurement process.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.42(17A) Requests for timely filing of an appeal. Any bidder that receives either a notice of disqualification or a notice of award, and has first exhausted the reconsideration process, is considered an aggrieved party and may file a written appeal with the department.

7.42(1) An aggrieved party in a competitive procurement must seek reconsideration of a disqualification or a notice of award prior to filing any appeal. The request for reconsideration must be received by the department within five days of the date of either a disqualification notice or notice of award. The department will expeditiously address the request for reconsideration and issue a decision on the reconsideration. If the party seeking reconsideration continues to be an aggrieved party following receipt of the decision on reconsideration, the aggrieved party may file an appeal within five days of the date of the department's decision on reconsideration.

7.42(2) The written appeal shall state the grounds upon which the appellant challenges the department's decision.

7.42(3) The day after the department's decision on reconsideration is issued is the first day of the period in which the appeal may be filed. The mailing address is: Department of Human Services, Appeals Section, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Appeals may also be sent by fax, email, or in-person delivery.

When an appeal is submitted through an electronic delivery method, such as electronic mail or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method or the appeal was filed via in-person delivery, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

441—7.43(17A) Bidder appeals. The bidder appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of Division II. Division I of this chapter does not apply to competitive procurement bid appeals, unless otherwise noted.

7.43(1) Hearing time frame. The presiding officer shall hold a hearing on the bidder appeal within 60 days of the date the notice of appeal was received by the department.

7.43(2) Registration. Upon receipt of the notice of appeal, the department shall register the appeal.

7.43(3) Acknowledgment. Upon receipt of the notice of appeal, the department shall send a written acknowledgment of receipt of the appeal to the appellant, representative, or both. The appropriate department staff will be notified of the appeal.

7.43(4) Granting a hearing. The department shall determine whether an appellant may be granted a hearing and the issues to be discussed at the hearing in accordance with the applicable rules, statutes or federal regulations or request for proposal.

a. The appeals of those appellants who are granted a hearing shall be certified to the department of inspections and appeals for the hearing to be conducted. The department shall indicate at the time of certification the issues to be discussed at the hearing.

b. Appeals of those appellants that are denied a hearing shall not be closed until a letter is sent to the appellant and the appellant's representative advising of the denial of the hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial may present additional information relative to the reason for denial and request reconsideration by the department over the denial.

7.43(5) Hearing scheduled. For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in the department of inspections and appeals rules in 481—Chapter 10 unless otherwise designated by federal or state statute or regulation.

7.43(6) Method of hearing. The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.8(17A).

7.43(7) Reschedule requests. Requests made by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals, except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals. All requests concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

7.43(8) Notification. For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

a. The notice shall comply with Iowa Code section 17A.12(2), and include a statement that opportunity shall be afforded to all parties to respond and present evidence on all issues involved and to be represented by counsel at their own expense.

b. A copy of this notice shall be made available to the department employee who took the action and to any other parties to the appeal.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.44(17A) Procedures for bidder appeal.

7.44(1) Discovery. The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

7.44(2) Witnesses and exhibits. The parties shall contact each other regarding witnesses and exhibits at least ten days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

7.44(3) Amendments to notice of appeal. The aggrieved bidder may amend the grounds upon which the bidder challenges the department's award no later than 15 days prior to the date set for the hearing.

7.44(4) If the hearing is not conducted in person, the parties must deliver all exhibits to the office of the presiding officer at least three days prior to the time the hearing is conducted.

7.44(5) The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to the appellant and representative by mail.

7.44(6) The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.45(17A) Stay of agency action for bidder appeal.

7.45(1) *When a stay may be requested.*

a. Any party appealing the issuance of a notice of disqualification or notice of award may petition for stay of the decision pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

b. Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order and shall state the reasons justifying a stay.

7.45(2) *When a stay is granted.* In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5)“c.”

7.45(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the department or any other party.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.46(17A) Request for review of the proposed decision. A request for review of the proposed decision shall follow the provisions outlined in rule 441—7.11(17A).

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 3787C, IAB 5/9/18, effective 7/1/18; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.47(17A) Other procedural considerations.

7.47(1) *Consolidation—severance.*

a. *Consolidation.* The presiding officer may, upon motion by any party or the presiding officer's own motion, consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues; and
- (3) Consolidation would not adversely affect the rights of parties to those proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

b. Severance. The presiding officer may, upon motion by any party or upon the presiding officer's own motion, for good cause shown, order any proceeding or portion thereof severed.

7.47(2) Presiding officer. Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals.

7.47(3) Rights of appellants during hearings. All rights afforded appellants at rule 441—7.8(17A) shall apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.48(17A) Appeal record.

7.48(1) The appeal record shall consist of all items specified in Iowa Code section 17A.16.

7.48(2) The party that requests a transcription of the proceedings shall bear the cost.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.49(17A) Pleadings.

7.49(1) Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

7.49(2) Petition. When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

7.49(3) Answer. If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

b. The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

d. Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

7.49(4) Amendment. Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

[ARC 1206C, IAB 12/11/13, effective 1/15/14]

441—7.50(17A) Ex parte communications. The rules regarding ex parte communications specified in subrule 7.9(1) and Iowa Code section 17A.17 apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

441—7.51(17A) Right of judicial review. The rules regarding right of judicial review specified in subrule 7.12(3) and Iowa Code section 17A.19 apply.

[ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 4972C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code chapter 17A.

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◊ Two or more ARCs

CHAPTER 14
OFFSET OF COUNTY DEBTS OWED DEPARTMENT

PREAMBLE

These rules provide a process for the department (1) to identify counties that owe liabilities to the department and (2) to cooperate with the department of administrative services for offsetting the counties' claims against state agencies with the liabilities which those counties owe the department. The process for identifying counties that owe liabilities and the process for offset each include notice and opportunity to be heard.

441—14.1(217,234) Definitions.

“Department” means the Iowa department of human services.

“Director” is the director of the Iowa department of human services.

“Liability” or *“debt”* means any liquidated sum due and owing to the department which has accrued through contract, subrogation, tort, operation of law, or any legal theory regardless of whether there is an outstanding judgment for that sum. Before setoff, the amount of a county's liability to the department shall be at least \$50.

“Offset” shall mean to set off or compensate the department which has a legal claim against a county where there exists a county's valid claim on a state agency that is in the form of a liquidated sum due, owing and payable. Before setoff, the amount of a county's claims on a state agency shall be at least \$50. The offset process shall not begin until the department has responded in writing to the county's request to resolve the unpaid bill.

441—14.2(217,234) Identifying counties with liabilities.

14.2(1) *Notice to county regarding liability.* When a bill to the county remains unpaid 60 calendar days following the date of the bill, the county shall be given written notice by the department. This notice shall:

- a. State the amount due, the name of the patient or client, and the dates of service.
- b. State the department's intent to use the offset program as provided in department of administrative services rules 11—Chapter 40.
- c. Require the county to send a written request for review to the division of fiscal management within 30 calendar days of the date of notification if the county disputes the bill.

14.2(2) *Request for administrative review.* The county may request an administrative review by providing to the division of fiscal management within 30 calendar days of the date of the notice of liability a written response that states why the county disagrees with the amount owed. The county shall provide any relevant legal citations, client identifiers, and any additional information supporting the county's position.

14.2(3) *Administrative review.* The division of fiscal management shall review within 30 calendar days of receipt of the written request the basis for the bill and the county's position as stated in the written request for review. The division of fiscal management shall notify the county of the findings of the review in writing within 30 days of receipt of the written request.

a. The division shall make the necessary adjustments to subsequent billings sent to the county when the division agrees with the county's position regarding the liability and shall so notify the county.

b. Any further disputes concerning the amount due shall be addressed when the offset notice is issued pursuant to rule 441—14.4(217,234).

441—14.3(217,234) List of counties with amounts owed.

14.3(1) *Notification to department of administrative services.* The division of fiscal management shall provide to the department of administrative services a list of the counties with amounts owed as established through rule 441—14.2(217,234). This list shall be maintained by the department of administrative services in a liability file.

14.3(2) Notification of change. The division of fiscal management shall notify the department of administrative services of any change in the status of a debt in the liability file within 30 calendar days from the occurrence of the change.

14.3(3) Certification of file. The division of fiscal management shall certify the file to the department of administrative services semiannually in a manner prescribed by the department of administrative services.

441—14.4(217,234) Notification to county regarding offset.

14.4(1) Notice. The division of fiscal management shall send notification to the county within ten calendar days from the date the department of administrative services notifies the division of a potential offset. This notification shall include:

- a. The department's right to the payment in question.
- b. The department's right to recover the payment through this offset procedure.
- c. The basis of the department's case in regard to the debt.
- d. The right of the county to request the split of the payment between parties when the payment in question is jointly owned or otherwise owned by two or more persons.
- e. The county's right to appeal the offset pursuant to 441—Chapter 7.
(1) and (2) Rescinded IAB 8/7/02, effective 9/11/02.
- f. Rescinded IAB 2/5/03, effective 2/1/03.
- g. The telephone number for the county to contact in the case of questions.

14.4(2) Copy of notice. The department of administrative services may require a copy of this notice be sent to it.

14.4(3) Appeal request.

- a. The county shall have 30 days to request an appeal. The county shall waive any right to appeal if the county fails to respond within 30 calendar days of the date of the notification.
- b. The request for appeal should include any relevant legal citations and any additional information supporting the county's position. If the county believes it has provided all relevant information as a part of the disputed-billing process, the county may instead note that the department already has the relevant information.
- c. The county's request for appeal shall suspend the offset action until a final appeal decision is issued.

441—14.5(217,234) Implementing the final decision. When the final decision issued pursuant to rule 441—7.12(17A) upholds the department's action or modifies the amount of offset, the division of fiscal management shall certify to the department of administrative services that the requirements for offset under Iowa Code section 8A.504 have been met. When the final decision reverses the department's action, the division of fiscal management shall notify the department of administrative services to release the offset.

14.5(1) and 14.5(2) Rescinded IAB 8/7/02, effective 9/11/02.
[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—14.6(217,234) Offset completed.

14.6(1) Offset implemented. The department of administrative services shall make the offset as prescribed in rule 11—40.7(8A).

14.6(2) Notification to county. Once the offset has been completed, the division of fiscal management shall notify the county of the action taken along with the balance, if any, still due to the department.

14.6(3) Duty of the department. The department shall pay to the county any payment offset by the department of administrative services to which the department is not entitled, in accordance with established procedures.

These rules are intended to implement Iowa Code sections 217.6 and 234.6.

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¹ Effective date of amendments to 14.2 to 14.6 delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002.

CHAPTER 15
RESOLUTION OF LEGAL SETTLEMENT DISPUTES
Rescinded **ARC 4610C**, IAB 8/14/19, effective 9/18/19

CHAPTER 16 NOTICES

PREAMBLE

This chapter applies to any notice of decision or notice of action issued by or on behalf of the department.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—16.1(17A) Definitions.

441—16.2441—16.2441—16.2441—16.2441—16.2441—16.2

“*Adequate notice*” means any notice of decision or notice of action issued in compliance with subrule 16.3(2).

“*Adverse benefit determination*” means any adverse action taken in regard to any individual’s benefits pursuant to an assistance program administered by the department or on the department’s behalf, excluding determinations related to requests for exceptions to policy.

“*Assistance program*” means a program administered by the department or on the department’s behalf through which qualifying individuals receive benefits or services. Assistance programs include, but are not necessarily limited to, food assistance, Medicaid, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, the family self-sufficiency grant, PROMISE JOBS, state supplementary assistance, the healthy and well kids in Iowa (hawki) program, foster care, adoption, and aftercare services.

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

“*Enrollee*” means any applicant for, or recipient of, benefits or services pursuant to an assistance program.

“*Timely*” means that the notice is sent at least ten calendar days before the date the adverse benefit determination would become effective. The timely notice period shall begin on the day after the notice is sent.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—16.2(17A) Governing laws and regulations. Notwithstanding the rules contained in this chapter, to the extent that state or federal law (including regulations and rules) related to a specific program is more specific than or contradicts these rules, the program-specific state or federal law shall control.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—16.3(17A) Notices.

16.3(1) Timely notice. For individuals applying for, or receiving, benefits pursuant to an assistance program, the department will provide timely, written notice of the right to appeal any adverse benefit determinations affecting the individual’s benefits or eligibility, when required to do so under state or federal law.

The department will also provide timely, written notice of pending actions for a state or federal tax or debtor offset.

Timely notice must also be adequate as provided in subrule 16.3(2).

16.3(2) Adequate notice. The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; pending action for a state or federal tax or debtor offset; or to the extent standards provided elsewhere in state or federal law are inapplicable. Adequate notice shall include:

- a. A description of the action taken;
- b. The effective date of the action;
- c. The specific reasons supporting the action, stated in clear language likely to be understood by the average program applicant or enrollee;
- d. References to applicable provisions of law supporting the action;
- e. An explanation of the right to appeal; and
- f. The circumstances under which assistance is continued when an appeal is filed.

16.3(3) *Dispensing with timely notice.* Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued, when:

a. There is factual information confirming the death of the enrollee or of the family investment program payee and there is no relative available to serve as a new payee.

b. The enrollee provides a clear written, signed statement that the enrollee no longer wishes to receive assistance, or gives information which requires termination or reduction of assistance, and the enrollee has indicated, in writing, that the enrollee understands that the consequence of supplying the information is termination or reduction of assistance.

c. The enrollee has been admitted or committed to an institution that does not qualify for payment under an assistance program.

d. The enrollee has been placed in skilled nursing care, intermediate care, or long-term hospitalization.

e. The whereabouts of the enrollee are unknown and mail directed to the enrollee has been returned by the post office indicating no known forwarding address. When the whereabouts of the enrollee become known during the payment period covered by the returned warrant, the warrant shall be made available to the enrollee.

f. The department establishes that the enrollee has been accepted for assistance in another state.

g. Cash assistance or food assistance is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.

h. A change in the level of medical care is prescribed by the enrollee's physician.

i. A special allowance or service granted for a specific period is terminated and the enrollee has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.

j. The notice involves an adverse determination made with regard to the preadmission screening requirements.

k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, as described at 441—subrule 40.27(3) or rule 441—75.52(249A).

l. The department terminates benefits for failure to return a completed report form, as described in paragraph 16.3(3)“*k.*”

m. The department approves or denies an application for assistance.

n. The department implements a mass change based on law or rule changes that affect a group of enrollees.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code chapter 17A.

[Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]

TITLE II

CHAPTERS 17 to 21

Reserved

TITLE IV
FAMILY INVESTMENT PROGRAM
CHAPTER 40
APPLICATION FOR AID
[Prior to 7/1/83, Social Services[770] Ch 40]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—40.1 to 40.20 Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, 441—40.1(239) to 40.9(239)]

441—40.21(239B) Definitions.

“Applicant” means a person for whom assistance is being requested, parent(s) living in the home with the child(ren), and the nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child(ren).

“Assistance unit” includes any person whose income is considered when determining eligibility or the family investment program grant amount.

“Casino, gambling casino, or gaming establishment” means an establishment with a primary purpose of accommodating the wagering of money. It does not include:

1. A grocery store which sells groceries including staple foods and which also offers, or is located within the same building or complex as, casino, gambling, or gaming activities; or
2. Any other establishment that offers casino, gambling, or gaming activities incidental to the principal purpose of the business.

An automated teller machine (ATM) or a point-of-sale (POS) terminal located within those areas of an establishment where individuals are banned due to age restrictions associated with gambling, established by state or federal law or by any other regulatory entity having the authority to do so, is considered to be in a casino, gambling casino, or gaming establishment.

“Central office” shall mean the state administrative office of the department of human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or *“dependent children”* means a child or children who meet the nonfinancial eligibility requirements of the family investment program.

“Electronic benefit transfer transaction” means the use of a credit or debit card service, automated teller machine, point-of-sale terminal, or access to an online system for the withdrawal of funds or the processing of a payment for merchandise or a service.

“Income in kind” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary or in-kind benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“Initial two months” means the first two consecutive months for which assistance is paid. This may include a month for which a partial payment is made.

“Liquor store” means any retail establishment which sells exclusively or primarily intoxicating liquor or other alcoholic beverages. Such term does not include a grocery store which sells both intoxicating liquor and groceries including staple foods (within the meaning of Section 3(r) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(r))).

Unless exempt as described in this definition, a retail establishment meets the definition of a liquor store when it has a North American Industry Classification System (NAICS) number that categorizes the retail establishment as either a beer, wine and liquor store or as a drinking place (alcoholic beverages). A retail establishment that does not have either type of NAICS code is considered to exclusively or primarily sell intoxicating liquor when 95 percent or more of the retail establishment's gross sales are from intoxicating liquor and it is not a United States Department of Agriculture-certified Supplemental Nutrition Assistance Program (SNAP) retailer.

Whenever "*medical institution*" is used in this title, it shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals
2. Extended care facilities (skilled nursing)
3. Intermediate care facilities
4. Mental health institutions
5. Hospital schools

"*Needy specified relative*" means a nonparental specified relative, listed in 441—subrule 41.22(3), who meets all the eligibility requirements to be included in the family investment program.

"*Parent*" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"*Payment month*" means the calendar month for which assistance is paid.

"*Payment standard*" means the total needs of a group as determined by adding need according to the schedule of basic needs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

"*Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program*" means the department's work and training program as described in 441—Chapter 93.

"*Prospective budgeting*" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"*Qualified alien*" means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is admitted to the United States as an Amerasian as described in 8 U.S.C. Section 1612(b)(2)(A)(ii)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c); or
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.

"*Qualifying quarters*" means all of the qualifying quarters of coverage as defined under Title II of the Social Security Act that were worked by a parent of an alien while the alien was under the age of 18 and all of the qualifying quarters that were worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996,

may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

“Recipient” means a person for whom assistance is paid, parent(s) living in the home with the eligible child(ren) and nonparental relative as defined in 441—subrule 41.22(3) who is receiving assistance for the child(ren). Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“Retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment” means an establishment that includes live entertainment at locations such as, but not limited to, strip clubs and gentleman’s clubs. It also includes stores and theaters that exclusively or primarily sell or feature adult-oriented videos and movies such as, but not limited to, adult book stores and adult movie theaters. A retail establishment meets this definition when the department has confirmed the primary nature of the business through the description on the business’s website, phone contact with the establishment, a site visit, or other means such as common local knowledge.

“Standard of need” means the total needs of a group as determined by adding need according to the schedule of living costs, described in 441—subrule 41.28(2), to any allowable special needs, described in 441—subrule 41.28(3).

“Stepparent” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent, by ceremonial or common-law marriage.

“Unborn child” shall include an unborn child during the entire term of the pregnancy.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5, and 239B.6.
[ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 2812C, IAB 11/9/16, effective 1/1/17]

441—40.22(239B) Application. The application for the family investment program shall be submitted on the Financial Support Application, Form 470-0462 or Form 470-0462(S). The application shall be signed by the applicant, the applicant’s authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant’s behalf. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and attest to the information for the assistance unit.

40.22(1) Each individual wishing to do so shall have the opportunity to apply for assistance without delay. When the parent is in the home with the child and is not prevented from acting as payee by reason of physical or mental impairment, this parent shall make the application.

40.22(2) An applicant may be assisted by other individuals in the application process; the client may be accompanied by such individuals in contact with the department, and when so accompanied, may also be represented by them. When the applicant has a guardian, the guardian shall participate in the application process.

40.22(3) The applicant shall immediately be given an application form to complete. When the applicant requests that the form be mailed, the department shall send the necessary forms in the next outgoing mail.

40.22(4) A new application is not required when adding a new person to the eligible group or when a parent or a stepparent becomes a member of the household.

40.22(5) Reinstatement.

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished, or the family meets the conditions described at 441—subparagraph 41.30(3)“*f*”(9). EXCEPTION: The reinstatement provisions of subrule 40.22(5) do not apply when assistance is canceled due to the imposition of a subsequent limited benefit plan as described at 441—subrule 41.24(8), unless the limited benefit plan is stopped as described in 441—paragraph 41.24(8)“*g*” or “*h*.”

b. When assistance has been canceled for failure to provide requested information, assistance shall be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall

have until the next business day to provide the information. The effective date of assistance shall be the date all information required to establish eligibility is provided.

c. When assistance has been canceled for failure to return a completed review form pursuant to subrule 40.27(3), assistance shall be reinstated without a new application if the completed form is received by the department within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date the Review/Recertification Eligibility Document is received.

d. When assistance has been canceled for failure to complete a required review interview, assistance shall be reinstated without a new application if the interview is completed and all necessary information to determine eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility is reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance shall be the date the interview is completed.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.
[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—40.23(239B) Date of application. The date of application is the date an identifiable Financial Support Application, Form 470-0462 or Form 470-0462(S), is received by the department. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open.

40.23(1) The date of application is also the date an identifiable application is received by a designated worker who is in any disproportionate share hospital, federally qualified health center or other facility in which outstationing activities are provided. The hospital, health center or other facility will forward the application to the department office that is responsible for the completion of the eligibility determination.

40.23(2) An identifiable application is an application containing a legible name and address that has been signed.

40.23(3) A new application is not required when adding a person to an existing eligible group. This person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be the date of the report.

a. In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the date of application to add the person is the date the person indicated willingness to cooperate.

b. EXCEPTIONS:

(1) When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the date of application to add the person is the date the social security number or proof of application for a social security number is provided.

(2) When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.23(5) or 41.25(5) or rule 441—46.29(239B), the date of application to add the person is the first day after the period of ineligibility has ended.

(3) When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the date of application to add the person is the date the person signs a family investment agreement.

40.23(4) Grace period.

a. When an application has been denied for failure to provide requested information, if all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date all of the information is provided.

b. When an application has been denied for failure to attend an interview, if the interview is completed and all necessary information to establish eligibility, including verification of any changes, is provided within 14 days of the date of denial, a new application is not required. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information. If eligibility can be established, the effective date of assistance is the date the interview is completed or the date all of the information is provided, whichever is later.

This rule is intended to implement Iowa Code section 239B.2.
[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—40.24(239B) Procedure with application.

40.24(1) The decision with respect to eligibility shall be based primarily on information furnished by the applicant.

a. The applicant shall report no later than at the time of the interview any change as defined at 40.27(4) “*e*” that occurs after the application was signed. Any change that occurs after the interview shall be reported by the applicant within five days from the date the change occurred.

b. The department shall notify the applicant in writing of additional information or verification that is required to establish eligibility for assistance. Failure of the applicant to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources shall serve as a basis for denial of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

(1) Five working days shall be considered as a reasonable period for the applicant to supply the required information or verification. The department shall extend the deadline when the applicant requests an extension because the applicant is making every effort to supply the information or verification but is unable to do so.

(2) “Supply” shall mean the requested information is received by the department by the specified due date. Any time taken beyond the required time frame shall be considered a delay on the part of the applicant.

c. When an individual is added to an existing eligible group, the five-day requirement for reporting changes shall be waived. These individuals and eligible groups shall be subject to the recipient’s ten-day reporting requirement as defined in 40.27(4).

40.24(2) The department or the designated worker as described in subrule 40.23(1) shall conduct a face-to-face or telephone interview with the applicant before approval of the application for assistance.

a. The worker shall assist the applicant, when requested, in providing information needed to determine eligibility and the amount of assistance.

b. The application process shall include a visit, or visits, to the home of the child and the person with whom the child will live during the time assistance is granted under the following circumstances:

(1) When it is the judgment of the worker or the supervisor that a home visit is required to clarify or verify information pertaining to the eligibility requirements; or

(2) When the applicant requests a home visit for the purpose of completing a pending application.

c. When adding an individual to an existing eligible group, the interview requirement may be waived.

40.24(3) Rescinded IAB 1/14/09, effective 2/1/09.

40.24(4) The decision with respect to eligibility shall be based on the applicant’s eligibility or ineligibility on the date the department enters all eligibility information into the department’s computer system, except as described in subrule 40.24(3). The applicant shall become a recipient on the date all eligibility information is entered into the department’s computer system and the computer system determines the applicant is eligible for aid.

This rule is intended to implement Iowa Code sections 239B.3, 239B.5 and 239B.6.
[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—40.25(239B) Time limit for decision. A determination of approval or denial shall be made as soon as possible, but no later than 30 days following the date of filing an application. A written notice of decision shall be issued to the applicant the next working day following a determination of eligibility

or ineligibility. This time standard shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department. When eligibility is dependent upon the birth of a child, the time limit may be extended while awaiting the birth of the child. When it becomes evident that due to an error on the part of the department, eligibility will not be established within the 30-day limit, the application shall be approved pending a determination of eligibility.

This rule is intended to implement Iowa Code sections 239B.3, 239B.4, 239B.5 and 239B.6.

441—40.26(239B) Effective date of grant. New approvals shall be effective as of the date the applicant becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date of application. When an individual is added to an existing eligible group, the individual shall be added effective as of the date the individual becomes eligible for assistance, but in no case shall the effective date be earlier than seven days following the date the change is reported. When it is reported that a person is anticipated to enter the home, the effective date of assistance shall be no earlier than the date of entry or seven days following the date of report, whichever is later.

When the change is timely reported as described at subrule 40.27(4), a payment adjustment shall be made when indicated. When the individual's presence is not timely reported as described at subrule 40.27(4), excess assistance issued is subject to recovery.

In those instances where a person previously excluded from the eligible group as described at 441—subrule 41.27(11) is to be added to the eligible group, the effective date of eligibility shall be seven days following the date the person indicated willingness to cooperate. However, in no instance shall the person be added until cooperation has actually occurred.

EXCEPTIONS: When adding a person who was previously excluded from the eligible group for failing to comply with 441—subrule 41.22(13), the effective date of eligibility shall be seven days following the date that the social security number or proof of application for a social security number is provided.

When adding a person who was previously excluded from the eligible group as described at 441—subrules 41.23(5), 41.25(5) and 46.28(2) and rule 441—46.29(239B), the effective date of eligibility shall be seven days following the date that the period of ineligibility ended.

When adding a person who was previously excluded from the eligible group as described at 441—subrule 41.24(8), the effective date of eligibility shall be seven days following the date the person signs a family investment agreement. In no case shall the effective date be within the six-month ineligibility period of a subsequent limited benefit plan as described at 441—paragraph 41.24(8) "a."

This rule is intended to implement Iowa Code section 239B.3.

441—40.27(239B) Continuing eligibility.

40.27(1) Eligibility factors shall be reviewed at least every six months for the family investment program. An interview may be conducted at the time of a review.

40.27(2) A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances (for example, a change in income, as defined at rule 441—40.21(239B)), or

b. A change in the recipient's circumstances comes to the attention of a staff member.

40.27(3) Information for semiannual reviews shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED).

a. The department shall supply the review form to the recipient as needed or upon request. The department shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the department by the seventh day after the date it is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

b. When the client has completed Form 470-0462 or Form 470-0462(S), Financial Support Application, for another purpose, this form may be used as the review document.

c. The review form shall be signed by the payee, the payee's authorized representative, or, when the payee is incompetent or incapacitated, someone acting responsibly on the payee's behalf.

40.27(4) Responsibilities of recipients. For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility and the amount of the family investment program grant.

b. The recipient shall complete the required review form when requested by the department in accordance with subrule 40.27(3). Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated and accompanied by verification as required in 441—paragraphs 41.27(1)“*i*” and 41.27(2)“*h*.”

c. The recipient has the primary responsibility for providing information and verification needed to establish eligibility and the amount of the family investment program grant. The recipient shall supply, insofar as the recipient is able, information and verification needed within ten working days from the date a written request is mailed by the department to the recipient's current mailing address or given to the recipient. The department shall extend the deadline when the recipient requests an extension because the recipient is making every effort to supply the information or verification but is unable to do so.

(1) “Supply” shall mean that the requested information or verification is received by the department by the specified due date.

(2) When the recipient is unable to furnish information or verification needed to establish eligibility and the amount of the family investment program grant, the recipient shall request assistance from the department.

(3) Failure to supply the information or verification requested or to request assistance and authorize the department to secure the requested information or verification from other sources shall serve as a basis for cancellation of assistance. Signing a general authorization for release of information to the department does not meet this responsibility.

d. The recipient or applicant shall cooperate with the department when the recipient's or applicant's case is selected by quality control for verification of eligibility. The recipient or applicant shall also cooperate with the front end investigations conducted by the department of inspections and appeals to determine whether information supplied to the department by the client is complete and correct regarding pertinent public assistance information unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect family investment program eligibility. (See department of inspections and appeals rules 481—Chapter 72.) Failure to cooperate shall serve as a basis for cancellation or denial of the family's assistance. Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

e. The recipient, or an individual being added to the existing eligible group, shall timely report any change in the following circumstances:

- (1) Beginning or ending income, including receipt of a nonrecurring lump sum.
- (2) Resources.
- (3) Members of the household.
- (4) School attendance of a child.
- (5) Mailing or living address.
- (6) Receipt of a social security number.

f. A report shall be considered timely when made within ten days from:

- (1) The receipt of resources or income or the date income ended.
- (2) The date the address changes.
- (3) The date the child is officially dropped from the school rolls.
- (4) The date a person enters or leaves the household.

(5) The receipt of a social security number.

g. When a change is not timely reported, any excess assistance paid shall be subject to recovery.

40.27(5) After assistance has been approved, eligibility for continuing assistance and the amount of the grant shall be effective as of the first of each month. Any change affecting eligibility or benefits reported during a month shall be effective the first day of the next calendar month except as follows:

a. When the recipient reports a new person to be added to the eligible group, and that person meets eligibility requirements, a payment adjustment shall be made for the month of report, subject to the effective date of grant limitations prescribed in 441—40.26(239B).

b. When cancellation of assistance occurs later because issuance of a timely notice, as required by rule 441—16.3(17A), requires that the action be delayed until the first day of the second calendar month, any overpayment received in the first calendar month shall be recouped.

c. When the recipient reports a change in income or circumstances timely, as defined in 40.24(1) or 40.27(4), the department shall determine prospective eligibility and the grant amount for the following month based on the change.

(1) A payment adjustment shall be made when indicated.

(2) Recoupment shall be made for any overpayment, with one exception. When a change in income is timely reported by a recipient and timely acted upon by the department, but the timely notice, as required by rule 441—16.3(17A), requires the action be delayed until the second calendar month following the month of change, and eligibility continues, recoupment shall not be made.

d. When an individual included in the eligible group becomes ineligible, that individual's needs shall be removed prospectively effective the first day of the next calendar month. When the action must be delayed due to administrative requirements, a payment adjustment or recoupment shall be made when appropriate.

e. When a sanction under 441—paragraph 41.22(6) "f" is implemented, the change shall be effective:

(1) The first day of the next calendar month after the change has occurred when the income maintenance unit determines noncooperation; or

(2) After the income maintenance unit receives notification from the child support recovery unit when the child support recovery unit determines noncooperation.

f. When a sanction under 441—paragraph 41.22(6) "f" is removed, the change shall be effective the first day of the next calendar month after the recipient has expressed willingness to cooperate, as described in 441—paragraph 41.22(6) "f." However, action to remove the sanction shall be delayed until:

(1) Cooperation has actually occurred; or

(2) The income maintenance unit has received notification from the child support recovery unit that the client has cooperated.

g. A different effective date shall be applied when specifically indicated in family investment program rules, such as in 441—subrule 41.25(5) and 441—subparagraph 41.27(9) "c"(2).

This rule is intended to implement Iowa Code sections 239B.2, 239B.3, 239B.5, 239B.6 and 239B.18.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 0148C, IAB 6/13/12, effective 8/1/12; ARC 1478C, IAB 6/11/14, effective 8/1/14; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—40.28(239B) Referral for investigation. The department may refer questionable cases to the department of inspections and appeals for further investigation.

This rule is intended to implement Iowa Code section 239B.5.

[ARC 4573C, IAB 7/31/19, effective 9/4/19]

441—40.29(239B) Conversion to the X-PERT system. Rescinded IAB 10/4/00, effective 12/1/00.

These rules are intended to implement Iowa Code chapter 239B.

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CHAPTER 41
GRANTING ASSISTANCE
[Prior to 7/1/83, Social Services[770] Ch 41]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
FAMILY INVESTMENT PROGRAM—
CONTROL GROUP
[Rescinded IAB 2/12/97, effective 3/1/97]

441—41.1 to 41.20 Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP
[Prior to 10/13/93, Human Services(441—41.1 to 41.9)]

441—41.21(239B) Eligibility factors specific to child.

41.21(1) Age. The family investment program shall be available to a needy child under the age of 18 years without regard to school attendance.

A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month. The family investment program shall also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, as defined in paragraph 41.24(2) "e," and who is reasonably expected to complete the program before reaching the age of 19.

41.21(2) Rescinded, effective June 1, 1988.

41.21(3) Residing with relative. The child shall be living in the home of one of the relatives specified in subrule 41.22(3). When an unwed mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

41.21(4) Rescinded, effective July 1, 1980.

41.21(5) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code sections 239B.1, 239B.2 and 239B.5.

441—41.22(239B) Eligibility factors specific to payee.

41.22(1) Reserved.

41.22(2) Rescinded, effective June 1, 1988.

41.22(3) Specified relationship.

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father—adoptive father.

Mother—adoptive mother.

Grandfather—grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather—adoptive grandfather.

Grandmother—grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother—adoptive grandmother.

Great-grandfather—great-great-grandfather.

Great-grandmother—great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother—brother-of-half-blood—stepbrother—brother-in-law—adoptive brother.

Sister—sister-of-half-blood—stepsister—sister-in-law—adoptive sister.

Uncle—aunt, of whole or half blood.

Uncle-in-law—aunt-in-law.

Great uncle—great-great-uncle.

Great aunt—great-great-aunt.

First cousins—nephews—nieces.

Second cousins, meaning the son or daughter of one's parent's first cousin.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

c. The family investment program is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

d. The presence of an able-bodied stepparent in the home shall not disqualify a child for assistance, provided that other eligibility factors are met.

41.22(4) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity.

a. When necessary to establish eligibility, the income maintenance unit shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family investment program family or other sources of information indicate that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the income maintenance unit shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.22(5) *Referral to child support recovery unit.* The income maintenance unit shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

a. A referral to the child support recovery unit shall not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. "Prompt notice" means within two working days of the date assistance is approved.

41.22(6) *Cooperation in obtaining support.* Each applicant for or recipient of the family investment program shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in 41.22(8) for refusal to cooperate is established.

a. The applicant or recipient shall cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

(4) Rescinded IAB 12/3/97, effective 2/1/98.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the office of the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

(4) Paying to the department any cash support payments for a member of the eligible group, except as described at 41.27(7)“p” and “q,” received by a recipient after the date of decision as defined in 441—subrule 40.24(4).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the income maintenance unit in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state’s attorney for any relevant judicial or administrative process.

e. In the circumstance as described at paragraph “b,” subparagraph (4), the income maintenance unit shall make the determination of whether or not the applicant or recipient has cooperated. In all other instances, the child support recovery unit shall make the determination of whether the applicant or recipient has cooperated. The child support recovery unit delegates the income maintenance unit to make this determination for applicants.

f. Failure to cooperate shall result in a sanction to the family. The sanction shall be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction shall be implemented after the noncooperation has occurred. The sanction shall remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction shall be delayed until cooperation has occurred.

(2) When the child support recovery unit (CSRU) makes the determination, the sanction shall be implemented upon notification from CSRU to the income maintenance unit that the client has failed to cooperate. The sanction shall remain in effect until the client has expressed to either income maintenance or CSRU staff willingness to cooperate. However, any action to remove the sanction shall be delayed until income maintenance is notified by CSRU that the client has cooperated.

41.22(7) Assignment of support payments. Each applicant for or recipient of assistance shall assign to the department any rights to support from any other person that the applicant or recipient may have. The assignment of support payments shall include rights to support in the applicant’s or recipient’s own behalf or in behalf of any other family member for whom the applicant or recipient is applying or receiving assistance.

a. The assignment of support payments shall include rights to all support payments that accrue during the period of assistance but shall not exceed the total amount of assistance received.

b. An assignment is effective the same date all eligibility information is entered into the department’s computer system and is effective for the entire period for which assistance is paid.

41.22(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child’s best interest when the applicant’s or recipient’s cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical harm to the child for whom support is to be sought; or
- (2) Emotional harm to the child for whom support is to be sought; or
- (3) Physical harm to the parent or caretaker relative with whom the child is living which reduces the person’s capacity to care for the child adequately; or
- (4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person’s capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child’s best interest when at least one of the following circumstances exists, and the income maintenance unit believes that

because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child for whom support is sought was conceived as a result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

41.22(9) Claiming good cause. Each applicant for or recipient of the family investment program who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the income maintenance unit shall notify the applicant or recipient using Form 470-0169, Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

- (1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.
- (2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the family investment program.
- (3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.
- (4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed; and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or recipient shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

- (1) Indicates that the applicant or recipient must provide corroborative evidence of a good cause circumstance and must, when requested, furnish sufficient information to permit the income maintenance unit to investigate the circumstances.
- (2) Informs the applicant or recipient that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.
- (3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the department's investigation when necessary, the income maintenance unit will determine whether cooperation would be against the best interest of the child for whom support would be sought.
- (4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

41.22(10) *Determination of good cause.* The income maintenance unit shall determine whether good cause exists for each applicant for or recipient of the family investment program who claims to have good cause.

a. The applicant or recipient shall be notified by the income maintenance unit of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in 41.22(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or recipient will be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after the unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

41.22(11) Proof of good cause. The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

(4) Medical records which indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing corroborative evidence, the income maintenance unit shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit will investigate the good cause claim when the unit believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and investigation which is conducted satisfies the income maintenance unit that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.22(12) *Enforcement without caretaker's cooperation.* When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve the participation of the child or caretaker.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination, and the income maintenance unit shall consider any recommendation from the child support recovery unit.

b. The determination shall:

- (1) Be in writing,
- (2) Contain the income maintenance unit's findings and basis for determination, and
- (3) Be entered into the family investment program case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.22(13) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement shall not apply to a payee who is not a member of the eligible group.

a. Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of 41.22(13).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described at 41.23(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.22(14) *Department of workforce development registration and referral.* Rescinded IAB 11/1/00, effective 1/1/01.

41.22(15) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive family investment program benefits unless good cause for not living with the parent or legal guardian is established.

a. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium or same row house as the adult parent or legal guardian. It also includes living in an apartment which is located in the home of the adult parent or legal guardian.

b. For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described at 441—subrule 40.24(2).

(1) If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child shall be approved as early as seven days from receipt of the application provided they are otherwise eligible.

(2) If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child shall be denied.

c. For recipients, when changes occur, continuing eligibility shall be redetermined according to 441—subrules 40.27(4) and 40.27(5).

d. A minor parent determined to have good cause for not living with a parent or legal guardian must attend FaDSS or other family development as required in 441—subrule 93.4(4).

41.22(16) *Good cause for not living in the home of a parent or legal guardian.* Good cause shall exist when at least one of the following conditions applies:

a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.
b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following shall be considered:

1. The present emotional state of the individual subject to emotional harm.

2. The emotional health history of the individual subject to emotional harm.

3. Intensity and probable duration of the emotional impairment.

c. The minor parent is in a foster care supervised apartment living arrangement.

d. The minor parent is participating in the job corps solo parent program.

e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department of human services.

g. Other circumstances exist which indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations which appear to meet this good cause reason must be referred to the administrator of the division of economic assistance, or the administrator's designee, for determination of good cause.

41.22(17) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian shall have the opportunity to claim good cause for not living with a parent or legal guardian.

41.22(18) *Determination of good cause for not living in the home of a parent or legal guardian.* The department shall determine whether good cause exists for each applicant or recipient who claims good cause.

a. The applicant or recipient shall be notified by the department of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the department's findings and basis for determination.

(3) Be entered in the family investment program case record.

b. When the department determines that good cause does not exist:

(1) The applicant or recipient shall be so notified.

(2) The application shall be denied or family investment program assistance canceled.

(3) Rescinded IAB 8/31/05, effective 11/1/05.

c. The department shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.22(19) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described at 441—subrule 40.24(1) and paragraph 40.27(4)“c.”

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim. Written statements from the client's friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records which verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the department wishes to request additional corroborative evidence which is needed to permit a good cause determination, the department shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the department shall:

(1) Advise the applicant or recipient how to obtain the necessary documents.

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

This rule is intended to implement Iowa Code chapter 239B.

[ARC 8004B, IAB 7/29/09, effective 10/1/09]

441—41.23(239B) Home, residence, citizenship, and alienage.

41.23(1) Iowa residence.

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.23(2) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

41.23(3) Absence from the home.

a. An individual who is absent from the home shall not be included in the assistance unit, except as described in paragraph "b."

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps,

Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as defined for children in 41.24(2) "e" and for adults in rule 441—93.8(239B), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code section 239B.2 and who meets either of the following requirements shall be eligible for participation in the family investment program:

a. The person is a conditional resident alien who was battered or subjected to extreme cruelty, or whose child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, as described in 8 CFR Section 216.5(a)(3).

b. The person was battered or subjected to extreme cruelty, or the person's child was battered or subjected to extreme cruelty, perpetrated by the person's spouse who is a United States citizen or lawful permanent resident, and the person's petition has been approved or a petition is pending that sets forth a prima facie case that the person has noncitizen status under any of the following categories:

(1) Status as a spouse or child of a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(1)(A).

(2) Status as a spouse or child who was battered or subjected to extreme cruelty by a United States citizen or lawful permanent resident under the federal Immigration and Nationality Act, Section 204(a)(iii), as codified in 8 United States Code Section 1154(a)(1)(A)(iii).

(3) Classification as a person lawfully admitted for permanent residence under the federal Immigration and Nationality Act.

(4) Suspension of deportation and adjustment of status under the federal Immigration and Nationality Act, Section 244(a), as in effect before the date of enactment of the federal Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

(5) Cancellation of removal or adjustment of status under the federal Immigration and Nationality Act, Section 240A, as codified in 8 United States Code Section 1229b.

(6) Status as an asylee, if asylum is pending, under the federal Immigration and Nationality Act, Section 208, as codified in 8 United States Code Section 1158.

41.23(5) *Citizenship and alienage.*

a. Eligible status. A family investment program assistance grant may include the needs of a citizen or national of the United States or a qualified alien as defined at rule 441—40.21(239B).

(1) A person who is a qualified alien as defined at rule 441—40.21(239B) is not eligible for family investment program assistance for a five-year period beginning on the date of the person's entry into the United States with a qualified alien status.

(2) EXCEPTIONS: The five-year prohibition from family investment program assistance does not apply to:

1. A qualified alien residing in the United States before August 22, 1996.

2. A battered alien as described at subrule 41.23(4).

3. A qualified alien veteran who has an honorable discharge that is not due to alienage.

4. A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

5. A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in numbered paragraph "3" or "4," including a surviving spouse who has not remarried.

6. A refugee admitted under Section 207 of the Immigration and Nationality Act (INA).
7. An alien granted asylum under Section 208 of the INA.
8. An alien admitted as an Amerasian as described in 8 U.S.C. Section 1612(a)(2)(A)(ii)(V).
9. A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
10. An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
11. An alien certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
12. An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. Attestation of status. As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and recipients on Form 470-0462 or 470-0462(S), Financial Support Application, or Form 470-2549, Statement of Citizenship Status. Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, may be used to attest to the citizenship of dependent children who enter a recipient household. Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligible group. The attestation may be signed by:

- (1) The applicant;
- (2) Someone acting responsibly on the applicant's or recipient's behalf if the applicant or recipient is incompetent or incapacitated; or
- (3) Any adult member of the assistance unit, when eligibility is determined on a family or household basis.

This rule is intended to implement Iowa Code sections 239B.2 and 239B.2B.
 [ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 1478C, IAB 6/11/14, effective 8/1/14]

441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. All persons in a family investment program (FIP) household shall be referred to the PROMISE JOBS program and shall enter into a family investment agreement (FIA) as a condition of receiving FIP, unless exempt from referral, except as described at subrule 41.24(2).

41.24(1) FIA-responsible persons. The following persons are FIA-responsible unless the department determines the person is exempt:

- a.* All persons whose needs are included in a grant under the FIP program.
- b.* Any parent living in the home of a child receiving a grant.
- c.* All FIP applicants unless the department determines that the applicant is exempt or does not meet other FIP eligibility requirements.
- d.* Applicants who have chosen and are in an active limited benefit plan (LBP). FIA-responsible applicants in an active limited benefit plan shall complete significant contact with or action in regard to PROMISE JOBS as described at paragraphs 41.24(8) "d" and "e" for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent is exempt. Exceptions:

- (1) The applicant has become exempt from PROMISE JOBS.
- (2) The applicant is in a subsequent limited benefit plan and it is prior to the last day of the six-month period of ineligibility.

41.24(2) Exemptions. The following persons are exempt from referral:

- a.* and *b.* Rescinded IAB 12/3/97, effective 2/1/98.
- c.* A person who is under the age of 16 and is not a parent.
- d.* A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.
- e.* A person who is aged 16 to 19, is not a parent, and attends an elementary, secondary or equivalent level of vocational or technical school full-time. For persons who lose exempt status for not

attending school, once the person has signed a family investment agreement, the person shall remain referred to PROMISE JOBS and subject to the terms of the agreement.

(1) A person shall be considered to be attending school full-time when enrolled or accepted in an elementary school, a secondary school, or the equivalent level of vocational or technical school or training leading to a certificate or diploma, and the school certifies the person's attendance as full-time. Enrollment in a correspondence school that gives instruction courses by mail is not an allowable program of study.

(2) A person shall also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, an illness, a convalescence, or a family emergency.

(3) A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

f. A person who is not a United States citizen and is not a qualified alien as defined in rule 441—40.21(239B).

41.24(3) Parents aged 19 and under.

a. Unless exempt as described at subrule 41.24(2), parents aged 18 or 19 are referred to PROMISE JOBS as follows:

(1) A parent aged 18 or 19 who has not successfully completed a high school education (or its equivalent) shall be required to participate in educational activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in other PROMISE JOBS options if the person fails to make good progress in completing educational activities or if it is determined that participation in educational activities is inappropriate for the parent.

(3) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

b. Unless exempt as described at subrule 41.24(2), parents aged 17 or younger are referred to PROMISE JOBS as follows:

(1) A parent aged 17 or younger who has not successfully completed a high school education or its equivalent shall be required to participate in high school completion activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent shall be required to participate in parenting skills training in accordance with 441—Chapter 93.

41.24(4) Method of referral. The department shall refer each FIA-responsible person as defined at subrule 41.24(1) to PROMISE JOBS to sign a family investment agreement.

a. FIA-responsible applicants. During the application interview, the department shall notify the applicant of the requirement to sign a family investment agreement as a condition of FIP eligibility. The department shall refer the applicant by scheduling the applicant for an appointment with the PROMISE JOBS provider agency to develop the family investment agreement.

(1) The appointment shall be on the earliest available date but no later than ten calendar days from the date of referral unless the applicant requests an appointment on a day that is beyond ten calendar days. The PROMISE JOBS provider agency shall make sufficient appointment times available to allow the applicant to be scheduled within this time frame.

(2) The applicant shall be notified verbally and in writing of the scheduled appointment. If the notice of a scheduled appointment is mailed to the applicant, the department shall allow at least five working days from the date the notice is mailed for the applicant to appear for the scheduled appointment. The department may allow less than five working days if the applicant is verbally notified and agrees to the appointment.

(3) If a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance for the entire family.

(4) If a minor parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance for the minor parent and any child of the minor parent.

(5) If a referred person who is not a parent fails to appear for an appointment without rescheduling or fails to sign a family investment agreement, the department shall deny FIP assistance only for that person.

b. Hardship applicants. While the eligibility decision is pending, unless the applicants are exempt from referral as defined in subrule 41.24(2), the department shall refer applicants who must qualify for a hardship exemption before approval of FIP to PROMISE JOBS to sign a family investment agreement as described in paragraph 41.24(4) "a" and shall treat applicants in accordance with subrule 41.30(3).

c. Applicants in a limited benefit plan. The department shall refer FIA-responsible applicants to PROMISE JOBS as described in paragraph 41.24(4) "a" and inform the applicant of the actions needed to reconsider and end the limited benefit plan as described at subrule 41.24(8). Failure to appear for the appointment without rescheduling or failure to sign a family investment agreement results in denial of the FIP application.

d. FIP participants who become FIA-responsible. When a person receiving FIP is no longer exempt, the department shall send the FIP participant a notice. The notice shall contain information about the requirement to sign a family investment agreement and shall instruct the FIP participant to contact PROMISE JOBS within ten calendar days to schedule an appointment with PROMISE JOBS to develop a family investment agreement. If the participant fails to schedule or attend the appointment or fails to sign a family investment agreement, PROMISE JOBS will send a clear written reminder. After one written reminder as described at 441—paragraph 93.3(3) "b," the participant shall enter into a limited benefit plan as described at paragraph 41.24(8) "c."

41.24(5) Changes in status and redetermination of exempt status. Any exempt person shall report any change affecting the exempt status to the department within ten days of the change. The department shall reevaluate exempt persons when changes in status occur and at the time of six-month or annual review. The participant and the PROMISE JOBS unit shall be notified of any change in a participant's exempt status.

41.24(6) Volunteers. Rescinded IAB 7/21/04, effective 9/1/04.

41.24(7) Referral to vocational rehabilitation. The department shall make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) Limited benefit plan (LBP). When a participant responsible for signing and meeting the terms of a family investment agreement as described at rule 441—93.4(239B) chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant shall enter into a limited benefit plan. A limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to the participant as defined at rule 441—16.3(17A). Once the limited benefit plan is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose a limited benefit plan, the person who chose the limited benefit plan can reconsider and end the limited benefit plan, but only as described at paragraphs 41.24(8) "d" and "e."

a. A limited benefit plan shall either be a first limited benefit plan or a subsequent limited benefit plan. From the effective date of a first limited benefit plan, the FIP eligible group or individual participant shall not be eligible until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8) "d." If a subsequent limited benefit plan is chosen by the same participant, a six-month period of ineligibility applies to the FIP eligible group or individual participant and ineligibility continues after the six-month period is over until the participant who chose the limited benefit plan completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8) "e." A limited benefit plan imposed in error as described in paragraph 41.24(8) "g" shall not be considered a limited benefit plan and shall not count when determining whether a household is subject to a subsequent limited benefit plan.

b. The limited benefit plan shall be applied to participants responsible for the family investment agreement and other members of the participant's family as follows:

(1) When the participant responsible for the family investment agreement is a parent, the limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1).

(2) When the participant choosing a limited benefit plan is a needy specified relative or a dependent child's stepparent who is in the FIP eligible group because of incapacity, the limited benefit plan shall apply only to the individual participant choosing the plan. EXCEPTION: The limited benefit plan shall apply to the entire FIP eligible group as defined at subrule 41.28(1) when a needy specified relative who assumes the role of parent was responsible for the family investment agreement and chose a limited benefit plan effective October 1, 2005, or earlier.

(3) When the FIP eligible group includes a minor parent living with the minor parent's adult parent or needy specified relative who receives FIP benefits and both the minor parent and the adult parent or needy specified relative are responsible for developing a family investment agreement, each parent or needy specified relative is responsible for a separate family investment agreement, and the limited benefit plan shall be applied as follows:

1. When the adult parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the entire eligible group, even though the minor parent has not chosen the limited benefit plan. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the family investment agreement process.

2. When the minor parent chooses the limited benefit plan, the requirements of the limited benefit plan shall apply to the minor parent and any child of the minor parent.

3. When the minor parent is the only eligible child in the adult parent's or needy specified relative's home and the minor parent chooses the limited benefit plan, the adult parent's or needy specified relative's FIP eligibility ceases in accordance with subrule 41.28(1). The adult parent or needy specified relative shall become ineligible beginning with the effective date of the minor parent's limited benefit plan.

4. When the needy specified relative chooses the limited benefit plan, the requirements of the limited benefit plan shall apply as described at subparagraph 41.24(8) "b"(2).

(4) When the FIP eligible group includes children who are FIA-responsible, the children shall not have a separate family investment agreement but shall be asked to sign the eligible group's family investment agreement and to carry out the responsibilities of that family investment agreement. A limited benefit plan shall be applied as follows:

1. When the parent or needy specified relative responsible for a family investment agreement meets those responsibilities but a child who is FIA-responsible chooses an individual limited benefit plan, the limited benefit plan shall apply only to the individual child choosing the plan.

2. When the child who chooses a limited benefit plan under numbered paragraph 41.24(8) "b"(4) "1" is the only child in the eligible group, the parents' or needy specified relative's eligibility ceases in accordance with subrule 41.28(1). The parents or needy specified relative shall become ineligible beginning with the effective date of the child's limited benefit plan.

(5) When the FIP eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are FIA-responsible, the children are responsible for completing a family investment agreement. If a child who is FIA-responsible chooses the limited benefit plan, the limited benefit plan shall be applied in the manner described in subparagraph 41.24(8) "b"(4).

(6) When both parents of a FIP child are in the home, a limited benefit plan shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for a family investment agreement and that parent chooses the limited benefit plan, the limited benefit plan applies to the entire family and cannot be ended by the voluntary participation in a family investment agreement by the exempt parent.

2. When both parents of a child in the eligible group are responsible for a family investment agreement, both are expected to sign the agreement. If either parent chooses the limited benefit plan,

the limited benefit plan cannot be ended by the participation of the other parent in a family investment agreement.

3. When the parents from a two-parent family in a limited benefit plan separate, the limited benefit plan shall follow only the parent who chose the limited benefit plan and any children in the home of that parent.

4. A subsequent limited benefit plan applies when either parent in a two-parent family previously chose a limited benefit plan.

c. A participant shall be considered to have chosen a limited benefit plan under any of the following circumstances:

(1) A participant who loses exempt status and is referred to PROMISE JOBS as described at paragraph 41.24(4)“*d*” and who does not schedule or attend an appointment for orientation and development of a family investment agreement with PROMISE JOBS after PROMISE JOBS sends one clear written reminder as described at 441—paragraph 93.3(3)“*b*” shall enter into the limited benefit plan.

(2) A participant who chooses not to sign the family investment agreement shall enter into the limited benefit plan. For an applicant, signing a family investment agreement is a FIP eligibility requirement. If an applicant chooses not to sign the agreement, the limited benefit plan process is not applicable.

(3) A participant who signs a family investment agreement but does not carry out the family investment agreement responsibilities shall enter into a limited benefit plan whether the person signed the agreement as a FIP applicant or as a FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker’s request to renegotiate the family investment agreement when the participant has not attained self-sufficiency by the date established in the family investment agreement. A limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the family investment agreement.

d. Reconsideration of a first limited benefit plan. A person who chooses a first limited benefit plan may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. To reconsider and end the limited benefit plan, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the family investment agreement.

(1) Since a first limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition. To end the limited benefit plan, the person must also sign a family investment agreement, even if the person had signed an agreement before choosing the limited benefit plan.

(2) FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.22(5) when the family investment agreement is signed before the effective date of a first limited benefit plan.

e. Reconsideration of a subsequent limited benefit plan. A person who chooses a subsequent limited benefit plan may reconsider that choice at any time following the required six-month period of ineligibility.

(1) A subsequent limited benefit plan is considered imposed as of the date that a timely and adequate notice is issued to establish the limited benefit plan. Therefore, once timely and adequate notice is issued, the person who chose the limited benefit plan cannot end it by complying with the issue that resulted in its imposition.

(2) FIP eligibility no longer exists as of the effective date of the limited benefit plan. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the limited benefit plan because the person is not eligible to sign a family investment agreement until the six-month period of ineligibility has expired.

(3) To reconsider and end the limited benefit plan, the person must:

1. Contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities,

2. Sign a new or updated family investment agreement, and

3. Satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service, unless problems as described at rule 441—93.14(239B) or barriers as described at 441—subrule 93.4(5) apply. The 20 hours of employment or other activity must be completed within 30 days of the date that the family investment agreement is signed, unless problems as described at rule 441—93.14(239B) or barriers as described at 441—subrule 93.4(5) apply.

(4) FIP benefits shall not begin until the person who chose the limited benefit plan completes the previously defined significant actions. FIP benefits shall be effective the date the family investment agreement is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

f. Reconsideration by two-parent family. For a two-parent family when both parents are responsible for a family investment agreement as described at subrule 41.24(1), a first or subsequent limited benefit plan continues until both parents have completed significant contact or action with the PROMISE JOBS program as described in paragraphs “*d*” and “*e*” above.

g. Limited benefit plan imposed in error. A limited benefit plan imposed in error shall not be considered a limited benefit plan. This includes any instance when participation in PROMISE JOBS should not have been required as described in the administrative rules. Examples of instances when an error has occurred are:

(1) The person was exempt from PROMISE JOBS participation at the time the person chose the limited benefit plan.

(2) It is verified that the person considered to have chosen the limited benefit plan moved out of state or requested cancellation of FIP prior to the date that PROMISE JOBS determined the limited benefit plan was chosen.

(3) The final appeal decision under 441—Chapter 7 reverses the decision to impose a limited benefit plan.

(4) It is determined that the entire amount of assistance issued for the person who chose the limited benefit plan is subject to recoupment for the month when the person chose not to fulfill the terms of the family investment agreement.

(5) The person informs PROMISE JOBS of a newly revealed problem as described at rule 441—93.14(239B) or barrier as described at 441—subrule 93.4(5) after the limited benefit plan is imposed, and it is reasonable that the problem or barrier contributed to a failure that resulted in imposition of the limited benefit plan. The person may be required to provide documentation of the problem or barrier as described at 441—subrule 93.10(3).

41.24(9) *Nonparticipation by volunteer participants.* Rescinded IAB 7/21/04, effective 9/1/04.

41.24(10) *Notification of services.*

a. The department shall inform all applicants for and recipients of FIP of the advantages of employment under FIP.

b. The department shall provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

c. The department shall provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information shall include explanations of child care assistance and transitional Medicaid.

d. The department shall inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

e. The department shall explain the LBP and the process by which FIA-responsible persons can choose the LBP.

f. The department shall inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department shall inform applicants for FIP benefits that a family investment agreement must be signed before FIP approval as a condition of eligibility, except as described at subrule 41.24(2). [ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1208C, IAB 12/11/13, effective 2/1/14; ARC 2272C, IAB 12/9/15, effective 2/1/16; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—41.25(239B) Uncategorized factors of eligibility.

41.25(1) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

41.25(2) *Duplication of assistance.* A recipient whose needs are included in a family investment program grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care or state-funded foster care.

a. A recipient shall not concurrently receive the family investment program and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family.

b. When a family investment program recipient is approved for foster care or subsidized adoption assistance while remaining in the same home, family investment program assistance shall be canceled effective the first day of the next calendar month following the date approval of the foster care or subsidized adoption payment is successfully entered into the department's computer system. FIP assistance for the month for which the foster care or subsidized adoption payment is approved or any past months for which foster care or subsidized adoption payments are made retroactively shall not be subject to recoupment.

c. A recipient shall not concurrently receive a grant from a public assistance program in another state.

d. When a recipient leaves the home of a specified relative, no payment for a concurrent period shall be made for the same recipient in the home of another relative.

41.25(3) *Aid from other funds.* Supplemental aid from any other agency or organization shall be limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance shall be considered unearned income.

41.25(4) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the family investment program when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.25(5) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living shall be ineligible for the family investment program for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual shall be ineligible for the family investment program for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

(2) An individual is not participating in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The district administrator shall determine whether such a risk to the individual's physical or emotional well-being exists.

41.25(6) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.25(7) *Time limit for receiving assistance.* Rescinded IAB 7/11/01, effective 9/1/01.

41.25(8) *School attendance requirements.* Rescinded IAB 7/7/04, effective 7/1/04.

41.25(9) Pilot diversion programs. Assistance shall not be approved when an assistance unit is subject to a period of ineligibility as described at 441—Chapter 47.

41.25(10) Fugitive felons, and probation and parole violators. Assistance shall be denied to a person who is (1) convicted of a felony under state or federal law and is fleeing to avoid prosecution, custody or confinement, or (2) violating a condition of probation or parole imposed under state or federal law. The prohibition does not apply to conduct pardoned by the President of the United States, beginning with the month after the pardon is given.

41.25(11) Access to benefits. As a condition of eligibility, applicants and recipients must agree in writing to not use an electronic access card at prohibited locations. By signing Form 470-0462 or 470-0462(S), Financial Support Application, or Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf agrees to this condition of eligibility. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and agree to this condition for the assistance unit. Failure to sign a form agreeing to not use the electronic access card at prohibited locations creates ineligibility for the entire eligible group.

a. A recipient shall not use the recipient's electronic access card issued pursuant to 441—subrule 45.21(1) to access benefits at any of the following prohibited locations as defined by federal statute or regulation applicable to this prohibition and as further defined in rule 441—40.21(239B):

- (1) A liquor store,
- (2) A casino, gambling casino, or gaming establishment, or
- (3) A retail establishment which provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

b. When the department receives a detailed complaint or suspects that a recipient has used the recipient's electronic access card at a prohibited location, the case shall be referred to the department of inspections and appeals for further investigation.

c. When the department of inspections and appeals finds that a recipient has used the recipient's electronic access card at a prohibited location, the household that includes the recipient is:

- (1) Considered to have committed a fraudulent act;
- (2) Liable for any amounts accessed and any associated fees for accessing the benefits at a prohibited location and required to repay such amount in accordance with 441—Chapter 46;
- (3) Ineligible for FIP for a three-month period after the first report by the department of inspections and appeals which includes a finding of misuse;
- (4) Ineligible for FIP for a six-month period after each subsequent report by the department of inspections and appeals which includes a finding of misuse.

d. When parents from a two-parent family separate during an ineligibility period, if:

- (1) The department of inspections and appeals investigation identifies the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow that recipient.
- (2) The department of inspections and appeals investigation does not identify the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow the recipient who is the case name when the violation occurred.

e. A new period of ineligibility shall be established when:

- (1) A recipient files an appeal either:
 1. Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or
 2. Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;
- (2) Assistance is continued pending the final decision of the appeal; and
- (3) The department's action is affirmed.

Assistance issued pending the final decision of an appeal is not subject to recovery pursuant to 441—subrule 7.9(6).

This rule is intended to implement Iowa Code chapter 239B.
[ARC 1207C, IAB 12/11/13, effective 2/1/14; ARC 1478C, IAB 6/11/14, effective 8/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15; ARC 2812C, IAB 11/9/16, effective 1/1/17]

441—41.26(239B) Resources.

41.26(1) Limitation. An applicant or recipient may have the following resources and be eligible for the family investment program. Any resource not specifically exempted shall be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at 41.26(1)“*n*” or “*o*” and 41.26(6)“*d*,” the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one’s home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of \$4115 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in 41.26(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of \$4115 of any vehicle shall be counted toward the resource limit in 41.26(1)“*e*.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

The department shall annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2000 for applicant assistance units and \$5000 for recipient assistance units. EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the \$5000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described at rules 441—45.26(239B) and 45.27(239B) and persons whose grants were suspended as in 41.27(9)“*f*” in the month prior to the month of application.

Resources of the applicant or the recipient shall be determined in accordance with subrule 41.26(2).

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined in 41.27(9)“*c*”(2)reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 41.27(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limitations unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in computing whether the eligible group's property is within the reserve defined in paragraph "e."

o. Nonhomestead property that produces income consistent with the property's fair market value.

41.26(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limitations.

b. Resources of the parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group shall be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income recipients shall not be counted in establishing property limitations.

e. The resources of a nonparental relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

f. and *g.* Rescinded IAB 10/4/00, effective 12/1/00.

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½-acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 41.26(5).

41.26(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 41.27(1) "f" and 41.27(7) "ah." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

41.26(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

41.26(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant/recipient owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all individuals hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

41.26(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

41.26(8) *Trusts.* The department shall determine whether assets from a trust or conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the trust agreement or order establishing a conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

b. When the department questions whether the funds in a trust or conservatorship are available, the trust or conservatorship shall be referred to the central office.

(1) When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(2) Funds in a trust or conservatorship that are not clearly available shall be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.26(9) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the resources of the alien shall be deemed to include the resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the resources of the sponsor and the sponsor's spouse deemed to the alien shall be the total countable resources as described in rule 441—41.26(239B) remaining after a \$1,500 deduction is subtracted. The following are exceptions to deeming of a sponsor's resources:

a. Deeming of the sponsor's resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at rule 441—40.21(239B);
or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's resources for 12 months after indigence is determined. An alien shall be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's resources for 12 months.

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, and inventory or supplies retained by the household shall not be considered a resource.

This rule is intended to implement Iowa Code section 239B.5.
[ARC 9439B, IAB 4/6/11, effective 6/1/11]

441—41.27(239B) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility and the amount of the family investment program grant.

1. The determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the family investment program grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group.

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group.

3. The amount of the family investment program grant shall be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)“h”(2) shall be considered as exempt income for the purpose of determining continuing eligibility, including child support as specified in paragraph 41.27(7)“q.” Deductions and diversions shall be allowed when verification is provided.

41.27(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Rescinded, effective December 1, 1986.

c. Rescinded, effective September 1, 1980.

d. Rescinded IAB 2/11/98, effective 2/1/98.

e. Rescinded IAB 2/11/98, effective 2/1/98.

f. When the applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

g. Every person in the eligible group and any parent living in the home of a child in the eligible group shall take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable

to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph (2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits shall be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2) "c."

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described at 441—subrule 40.27(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

h. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment for a member of the eligible group, made while the application is pending, shall be treated as unearned income and deducted from the initial assistance grant(s). Any cash support payment for a member of the eligible group, except as described at 41.27(7) "p" and "q," received by the recipient after the date of decision as defined in 441—subrule 40.24(4) shall be refunded to the child support recovery unit.

(2) Assigned support collected in a month and retained by child support recovery shall be exempt as income for determining prospective or retrospective eligibility. Participants shall have the option of withdrawing from FIP at any time and receiving their child support direct.

(3) and (4) Rescinded IAB 12/3/97, effective 2/1/98.

i. The applicant or recipient shall cooperate in supplying verification of all unearned income, as defined at rule 441—40.21(239B). When the information is available, the department shall verify job insurance benefits by using information supplied to the department by the department of workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day. When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A payment adjustment shall be made when indicated. Recoupment shall be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision, Form 470-0485(C) or 470-0486(M), applicable to the payment month, whichever is later, in order to receive a payment adjustment.

41.27(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. *Earned income deduction.* Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses shall include, but not be limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Rescinded IAB 12/29/99, effective 3/1/00.

c. *Work incentive disregard.* After deducting the allowable work-related expenses as defined in paragraph 41.27(2) "a" and income diversions as defined in subrules 41.27(4) and 41.27(8), the department shall disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered in determining eligibility and the amount of the assistance grant.

- (1) The work incentive disregard is not time-limited.
- (2) Initial eligibility is determined without the application of the work incentive disregard as described at subparagraphs 41.27(9)“a”(2) and (3).

d. Self-employment. A person is considered self-employed when the person:

- (1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.
- (2) Establishes the person’s own working hours, territory, and methods of work.
- (3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

e. Self-employment income. Earned income from self-employment as defined in paragraph 41.27(2)“d” means the net profit from self-employment. “Net profit” means gross self-employment income less:

- (1) Forty percent of the gross income to cover the costs of producing the income, or
- (2) At the request of the applicant or recipient, actual expenses determined in the manner specified in paragraph 41.27(2)“f.”

f. Deduction of self-employment expenses. When the applicant or recipient requests that actual expenses be deducted, the net profit from self-employment income shall be determined by deducting only the following expenses that are directly related to the production of the income:

- (1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.
- (2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.
- (3) The cost of shelter in the form of rent; the interest on mortgage or contract payments; taxes; and utilities.
- (4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.
- (5) Insurance on the real or personal property involved.
- (6) The cost of any repairs needed.
- (7) The cost of any travel required.
- (8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. Child care income. Gross income from providing child care in the applicant’s or recipient’s own home shall include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

h. Income verification. The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—40.21(239B). A self-employed individual shall keep any records necessary to establish eligibility.

41.27(3) Shared living arrangements. When a family investment program parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the family investment program eligible group, exclusively for their needs, are considered income.

41.27(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.21(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within family investment program standards. The maximum income that shall be diverted to meet the needs of the ineligible child(ren) shall be the difference between the needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in 41.27(8)“a”(2) and 41.27(8)“b.”

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

41.27(5) *Income of unmarried specified relatives under age 19.* Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the grant of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents shall be treated in accordance with subparagraphs (1), (2), and (4) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) shall be treated in accordance with 41.27(8) "c."

(3) Rescinded IAB 4/3/91, effective 3/14/91.

(4) When the unmarried specified relative is age 18, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority.

41.27(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when utilized by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

- k.* Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
- l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- m.* The income of a supplemental security income recipient.
- n.* Income of an ineligible child.
- o.* Income in-kind.
- p.* Family support subsidy program payments.
- q.* Grants obtained and used under conditions that preclude their use for current living costs.
- r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 41.22(3), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
 - s.* Rescinded IAB 2/11/98, effective 2/1/98.
 - t.* Any income restricted by law or regulation which is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.
 - u.* The first \$50 received and retained by an applicant or recipient which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
 - v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
 - (1) The loan is obtained from an institution or person engaged in the business of making loans.
 - (2) There is a written agreement to repay the money within a specified time.
 - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
 - w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
 - x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
 - y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
 - z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."
 - aa.* Payments received from the Radiation Exposure Compensation Act.
 - ab.* Deposits into an individual development account (IDA) when determining eligibility and benefit amount. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. The deposit shall be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in 41.27(2) "a" and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

ac. Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.27(1)“h”(2).

41.27(7) Exempt as income. The following are exempt as income.

- a.* Reimbursements from a third party.
- b.* Reimbursement from the employer for job-related expenses.
- c.* The following nonrecurring lump sum payments:
 - (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.
 - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d.* Payments received by the family providing foster care to a child or children when the family is operating a licensed foster home.
- e.* Rescinded IAB 5/1/91, effective 7/1/91.
- f.* A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.

- g.* Federal or state earned income tax credit.
- h.* Supplementation from county funds providing:
 - (1) The assistance does not duplicate any of the basic needs as recognized by the family investment program, or
 - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- i.* Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- j.* A retroactive corrective payment.
- k.* The training allowance issued by the division of vocational rehabilitation, department of education.
- l.* Payments from the PROMISE JOBS program.
- m.* Rescinded, effective July 1, 1989.
- n.* The training allowance issued by the department for the blind.
- o.* Payment(s) from a passenger(s) in a car pool.
- p.* Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- q.* Rescinded IAB 11/8/06, effective 1/1/07.
- r.* Rescinded IAB 11/8/06, effective 1/1/07.
- s.* Income of a nonparental relative as defined in 41.22(3) except when the relative is included in the eligible group.
- t.* Rescinded IAB 11/8/06, effective 1/1/07.
- u.* Rescinded IAB 9/11/96, effective 11/1/96.
- v.* Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- w.* Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
- x.* Rescinded, effective July 1, 1986.
- y.* Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in 41.24(2)“e.” The exemption applies through the entire month of the person’s twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

z. Income attributed to an unmarried, underage parent in accordance with 41.27(8) "c" effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18 on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

aa. Rescinded IAB 12/3/97, effective 2/1/98.

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. Rescinded IAB 12/3/97, effective 2/1/98.

ag. Rescinded IAB 11/8/06, effective 1/1/07.

ah. Welfare reform and regular household honorarium income. All moneys paid to a FIP household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ai. Diversion or self-sufficiency grants assistance as described at 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4) "b" and 41.27(1) "f."

ak. All census earnings received by temporary workers from the Bureau of the Census.

41.27(8) Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.

a. *Treatment of income in excluded parent cases.*

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described at paragraph 41.27(2) "a," the work incentive disregard described at paragraph 41.27(2) "c," and diversions described at subrule 41.27(4).

(2) The excluded parent shall be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described at subrule 41.27(11).

(3) All remaining income of the excluded parent shall be applied against the needs of the eligible group.

b. *Treatment of income in stepparent cases.* The income of a stepparent who is not included in the eligible group, but is living with the parent in the home of the eligible child(ren), shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) to (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) Rescinded IAB 6/30/99, effective 7/1/99.

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in 41.27(8) "b"(1) to (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for

federal income tax purposes. These needs shall be determined in accordance with the family investment program standard of need for a family group of the same composition.

(6) The stepparent shall be allowed the work incentive disregard described at paragraph 41.27(2) "c" from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions in subparagraphs 41.27(8) "b"(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 41.27(9) "a"(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt nonrecurring lump sum received by a stepparent shall be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described at 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parent(s), the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to 41.27(8) "b"(1) to (7). Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with 41.27(8) "b"(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to 41.27(8) "b"(1) to (7). Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with 41.27(8) "b"(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit; the self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

41.27(9) Budgeting process. Both initial and ongoing eligibility and benefits shall be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made shall be considered to determine eligibility for the family investment program, except income which is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview shall be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with 41.27(9)“c”(1) and 41.27(9)“i,” the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision shall be deducted from earned income, except when determining eligibility under the 185 percent test defined in rule 441—41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in rule 441—41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application shall be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in rule 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need shall then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application shall be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application shall be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the family investment program grant shall be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9)“a”(4).

(4) Eligibility for the family investment program for any month or partial month before the month of decision shall be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision shall be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family composition in that month shall be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described at subrule 41.30(1), family investment program eligibility shall be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

(6) Rescinded IAB 11/8/06, effective 1/1/07.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

b. Ongoing eligibility.

(1) The department shall prospectively compute eligibility and benefits when review information is submitted as described in 441—subrule 40.27(3). All countable earned and unearned income received by the eligible group during the previous 30 days shall be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the department shall prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Rescinded IAB 11/8/06, effective 1/1/07.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2)“a” and the work incentive disregard as defined in paragraph 41.27(2)“c” shall be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be considered as income in the month received. Income received by an individual employed under a contract shall be prorated over the period of the contract. Income received at periodic intervals or intermittently shall be considered as income in the month received, except periodic or intermittent income from self-employment shall be treated as described in 41.27(9) "i." When the income that is subject to proration is earned, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4) and 41.26(7) and paragraphs 41.27(8) "b" and 41.27(8) "c," shall be treated in accordance with this rule. Nonrecurring lump-sum income shall be considered as income in the month received and counted in computing eligibility and the amount of the grant, unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers' compensation. When countable income, exclusive of the family investment program grant but including countable lump-sum income, exceeds the needs of the eligible group, the case shall be canceled or the application rejected. In addition, the eligible group shall be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation shall be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility shall begin with the month the lump sum is received.

When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4) "f," recoupment shall not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by 441—subrule 16.3(1) requires that the action be delayed until the second calendar month following the month of change, recoupment shall not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment shall be made beginning with the month of receipt.

The period of ineligibility shall be shortened when the schedule of living costs as defined in 41.28(2) increases.

The period of ineligibility shall be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

The period of ineligibility shall also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum shall be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the family investment program as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment shall be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6) “*f.*”

e. In any month for which an individual is determined eligible to be added to a currently active family investment program case, the individual’s needs shall be included subject to the effective date of grant limitations as prescribed in 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual shall be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group shall be removed prospectively effective the first of the following month.

f. Rescinded IAB 11/8/06, effective 1/1/07.

g. When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3), (4), and (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3), (4) and (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in 41.28(3) must be documented before payment shall be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment shall be included, prospectively, in each month’s family investment program grant. When the special need ends, payment shall be removed prospectively. Any overpayment for a special need shall be recouped.

(5) Rescinded IAB 11/8/06, effective 1/1/07.

k. When a family’s assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the family

investment program as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home shall be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person shall be considered prospectively in accordance with 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income of the alien shall be deemed to include the income of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the income of the sponsor and the sponsor's spouse deemed to the alien shall be the total gross earned and unearned income remaining after allowing the earned income deduction described at paragraph 41.27(2) "a," the work incentive disregard described at paragraph 41.27(2) "c," and diversions described at subrule 41.27(4). The following are exceptions to deeming of a sponsor's income:

a. Deeming of the sponsor's income does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act;

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's income for 12 months after indigence is determined. An alien shall be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income for 12 months.

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.29(239B), or who is required to be included in the eligible group according to 41.28(1) "a" and has failed to cooperate. This restriction applies to 41.27(4) "a" and 41.27(8).

This rule is intended to implement Iowa Code section 239B.7.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 9043B, IAB 9/8/10, effective 11/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 0148C, IAB 6/13/12, effective 8/1/12; ARC 1478C, IAB 6/11/14, effective 8/1/14; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act. There shall be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons shall be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communi-cations	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
- (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
- (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
- (4) Food: Including school lunches.
- (5) Clothing: Including layette, laundry, dry cleaning.
- (6) Personal care and supplies: Including regular school supplies.
- (7) Medicine chest items.
- (8) Communications: Telephone, newspapers, magazines.
- (9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving the family investment program assistance for the relative's own children.

(2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the family investment program, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the family investment program but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the family investment program, the needs of the specified relative, when eligible, shall be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in 41.22(3), only the needs of the eligible

children shall be included in the assistance grant. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources shall not be considered in determining family investment program benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant shall be computed on the basis of their comprising one eligible group. This rule shall not be construed to require that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs shall be allowed, in addition to the basic needs.

a. School expenses. Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, shall be allowed provided the allowance shall not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. Guardian/conservator fee. An amount not to exceed \$10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

c. FIP special needs classroom training. Rescinded IAB 12/3/97, effective 2/1/98.

d. Job Training Partnership Act. Rescinded IAB 12/3/97, effective 2/1/98.

41.28(4) *Period of adjustment.* Rescinded IAB 11/1/00, effective 1/1/01.

This rule is intended to implement Iowa Code section 239B.5.

441—41.29(239B) Composite FIP/SSI cases. When persons in the family investment program household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following rules shall apply.

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the family investment program grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the family investment program recipient, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

This rule is intended to implement Iowa Code section 239B.5.

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance shall not be provided to a FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or under any program in another state that is funded by the federal Temporary Assistance for Needy Families (TANF) block grant unless the applicant or recipient family is eligible for a hardship as defined in subrule 41.30(3). The 60-month period need not be consecutive. In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

a. An "adult" is any person who is a parent of the FIP child in the home, the parent's spouse, or included as an optional member under subparagraph 41.28(1) "b"(1) or (2).

b. "Assistance," for the purpose of this rule, shall include any month for which the adult receives a FIP grant or a payment in another state using federal Temporary Assistance for Needy Families (TANF) funds that the other state deems countable toward the 60-month federal limit. Assistance received for a partial month shall count as a full month.

41.30(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department shall consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are supplemental security income (SSI) recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1)“b”(1) and (2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described at subparagraph 41.28(1)“b”(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent’s case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department shall not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

(3) Rescinded IAB 1/9/02, effective 3/1/02.

(4) Rescinded IAB 1/9/02, effective 3/1/02.

e. The department shall not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent’s or the specified relative’s FIP case.

f. The department shall not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 United States Code Section 1151) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.30(3) Exception to the 60-month limit. A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. “Hardship” is defined as a circumstance that is preventing the family from being self-supporting. However, the family’s safety shall take precedence over the goal of self-sufficiency.

a. Rescinded IAB 12/9/15, effective 2/1/16.

b. Eligibility determination. Eligibility for the hardship exemption shall be determined on an individual family basis. A hardship exemption shall not begin until the adult in the family has received at least 60 months of FIP assistance.

c. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include, but are not limited to, the following:

(1) Domestic violence. “Domestic violence” means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.

2. Sexual abuse.

3. Sexual activity involving a dependent child.

4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.

5. Threats of, or attempts at, physical or sexual abuse.

6. Mental abuse.

7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.4(5).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient shall follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance abuse issues. A family requesting a hardship exemption due to substance abuse shall be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include, but is not limited to, a child as defined in rule 441—170.1(234) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child shall take precedence over the goal of self-sufficiency.

(8) Rescinded IAB 1/8/03, effective 1/1/03.

(9) Other circumstances which prevent the family from being self-supporting.

d. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.

(2) Families with FIA-responsible persons who are not exempt from referral as defined in subrule 41.24(2) determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that an FIA-responsible person who is not exempt as defined in subrule 41.24(2) has that were known and existing before the family reached the 60-month limit shall not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

e. Requesting a hardship exemption.

(1) Families that have or are close to having received 60 months of assistance as defined in subrule 41.30(1) may request a hardship exemption. Requests for the hardship exemption shall be made on Form 470-3826 or Form 470-3826(S), Request for FIP Beyond 60 Months. In addition, families that have received assistance for 60 months shall complete Form 470-0462 or Form 470-0462(S), Financial Support Application, as described at rule 441—40.22(239B) as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department's request shall result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption shall not be accepted prior to the first day of the family's fifty-ninth month of assistance. The date of the request shall be the date an identifiable Form 470-3826 or Form 470-3826(S) is received in any department of human services or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.30(1) who has received assistance for 60 months joins a recipient family that has not received 60 months of assistance, eligibility shall continue only if the recipient family submits Form 470-3826 or Form 470-3826(S) and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period shall continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, shall follow the parent who retains the current FIP case.

f. Determination of hardship exemption.

(1) A determination on the request shall be made as soon as possible, but no later than 30 days following the date an identifiable Form 470-3826 or Form 470-3826(S) is received in any department of human services or PROMISE JOBS office. A written notice of decision shall be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption. The 30-day time standard shall apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information which has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) shall apply.

(3) Income maintenance shall determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department shall advise the applicant or recipient about how to obtain necessary documents. Upon request, the department shall provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter shall not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department shall notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family shall be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4)“c.” Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, shall result in denial of the family's request for a hardship exemption.

(7) Rescinded IAB 12/12/01, effective 11/14/01.

(8) Rescinded IAB 12/12/01, effective 11/14/01.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month shall be eligible for reinstatement as described at 441—subrule 40.22(5) when Form 470-3826 or Form 470-3826(S) is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When Form 470-3826 or Form 470-3826(S) is not received before the effective date of the FIP cancellation and a Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance shall be no earlier than seven days from the date of application as described at rule 441—40.26(239B).

(11) Eligibility for a hardship exemption shall last for six consecutive calendar months. EXCEPTION: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new Form 470-3826 or Form 470-3826(S). A new hardship exemption determination shall be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period shall count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

g. Six-month family investment agreement (FIA). Families who request a hardship exemption shall develop and sign a six-month family investment agreement (FIA) as defined at rule 441—93.4(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA unless the adult is a stepparent and is not requesting assistance or is exempt as specified at subrule 41.24(2).

(1) The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption shall require a new six-month FIA. Failure to develop or sign a six-month FIA shall result in denial of the family's hardship exemption request.

(2) Families that request a hardship exemption shall be notified verbally and shall be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days shall be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(3) Failure to attend a scheduled interview when required, except for reasons beyond the adult's control, shall result in a denial of the family's hardship exemption request. In two-parent families, both parents shall be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(4) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family at least once a month. These contacts need not be in person. Time and attendance reports shall be required as specified at 441—subrule 93.10(2).

(5) The six-month FIA shall be renegotiated and amended under the circumstances described at 441—subrule 93.4(8).

(6) Any family that is not exempt from referral as defined in subrule 41.24(2), that has been granted a hardship exemption, and that does not follow the terms of the family's six-month FIA will have chosen a limited benefit plan in accordance with 441—Chapters 41 and 93.

h. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 7.

This rule is intended to implement Iowa Code chapter 239B.

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¹ Two or more ARCs

² Two or more ARCs

³ Two ARCs

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CHAPTER 46
OVERPAYMENT RECOVERY

[Prior to 7/1/83, Social Services[770] Ch 46]

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

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

[Rescinded IAB 2/12/97, effective 3/1/97]

441—46.1 to 46.20 Reserved.

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

[Prior to 10/13/93, 441—46.1(239) to 46.8(239)]

441—46.21(239B) Definitions.

“*Agency error*” in overpayments means: (a) The same as circumstances described in 441—subrule 45.24(1) pertaining to underpayments, or (b) any error that is not a client or procedural error.

“*Client*” means a current or former applicant or recipient of the family investment program.

“*Client error*” means and may result from:

1. False or misleading statements, oral or written, regarding the client’s income, resources, or other circumstances which may affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances as required by rule 441—40.27(239B);
3. Failure to refund to the child support recovery unit any nonexempt payment from the absent parent received after the date the decision on eligibility was made; or
4. Access of benefits issued via the electronic access card at a prohibited location pursuant to 441—subrule 41.25(11).

“*Overpayment*” means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive or the amount of any payment accessed at a prohibited location pursuant to 441—subrule 41.25(11).

“*Procedural error*” means a technical error that does not in and of itself result in an overpayment. Procedural errors include:

1. Failure to secure a properly signed application at the time of initial application or reapplication.
2. Failure to secure a properly signed Form 470-3826 or Form 470-3826(S), Request for FIP Beyond 60 Months, as described at 441—subrule 41.30(3).
3. Failure of the department to conduct the interviews described in 441—subrules 40.24(2) and 40.27(1).
4. Failure to request a Review/Recertification Eligibility Document at the time of a semiannual or annual review.
5. Failure of department staff to cancel the family investment program benefits when the client submits a Review/Recertification Eligibility Document that is not complete as defined in 441—paragraph 40.27(4) “b.” However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

“*Recoup*” means reimburse, return, or repay an overpayment.

“*Recoupment*” means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

[ARC 1207C, IAB 12/11/13, effective 2/1/14; ARC 2272C, IAB 12/9/15, effective 2/1/16]

441—46.22(239B) Monetary standards.

46.22(1) *Amount subject to recoupment.* All family investment program overpayments shall be subject to recoupment.

46.22(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued shall be for no less than \$10.

441—46.23(239B) Notification and appeals. All clients shall be notified by the department of inspections and appeals, as described at 441—paragraph 7.4(3)“i,” when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client’s request. The client may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—paragraph 7.4(3)“i.”
[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—46.24(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision shall be recouped. A procedural error alone does not result in an overpayment.

46.24(1) Agency error. When an overpayment is due to an agency error, recoupment shall be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.22(6) or 41.22(7) from being met or when the client receives a duplicate grant.

a. An overpayment of any amount is subject to recoupment with one exception: When the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment shall be made only when the amount received exceeds the amount on the notice by \$10 or more.

b. An overpayment due to agency error shall be computed as if the information had been acted upon timely.

46.24(2) Assistance paid pending appeal decision. Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing shall begin no later than the month after the month in which the final decision is issued.

46.24(3) Client error.

a. An overpayment due to client error shall be computed as if the information had been reported and acted upon timely.

b. Overpayments due to failure to refund payments received from the absent parent shall be the total nonexempt support payment made for members of the eligible group at the time the support payment was received. In addition, assistance payments made to meet the needs of the eligible group may also be subject to recoupment under provisions in 441—subrule 41.22(6).

c. An overpayment due to a recipient’s accessing benefits via the electronic access card at a prohibited location shall be the total of the transactions and any associated fees for accessing the benefits at the prohibited location pursuant to 441—subrule 41.25(11).

46.24(4) Failure to cooperate. Failure to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months.

46.24(5) Overpayment in special alien cases. Rescinded IAB 10/4/00, effective 12/1/00.

46.24(6) Real property exempted as a resource. Rescinded IAB 6/30/99, effective 9/1/99.
[ARC 1207C, IAB 12/11/13, effective 2/1/14; ARC 2812C, IAB 11/9/16, effective 1/1/17]

441—46.25(239B) Source of recoupment. Recoupment shall be made from basic needs. The minimum recoupment amount shall be the amount prescribed in 46.25(3). Regardless of the source, the client may choose to make a lump sum payment, make periodic installment payments when an agreement to do this is made with the department of inspections and appeals, or have repayment withheld from the grant. The client shall sign Form 470-0495, Repayment Contract, when requested to do so by the department of inspections and appeals. When the client fails to make the agreed upon payment, the agency shall reduce the grant.

46.25(1) and 46.25(2) Rescinded, effective February 8, 1984.

46.25(3) Basic needs.

a. Recoupment by withholding from basic needs for overpayments due to client error or a combination of client and agency errors shall be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

b. Recoupment by withholding from basic needs for overpayments due to the continuation of benefits pending a decision on an appeal as provided under rule 441—7.9(217) or a combination

of continued benefits and agency or client errors shall be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

c. Recoupment by withholding from basic needs for overpayments due to agency error shall be 1 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

d. Rescinded IAB 6/30/99, effective 9/1/99.

46.25(4) *Recoupment in special alien cases.* Rescinded IAB 10/4/00, effective 12/1/00.

441—46.26 Rescinded, effective February 8, 1984.

441—46.27(239B) Procedures for recoupment.

46.27(1) Rescinded IAB 2/8/89, effective 4/1/89.

46.27(2) *Referral.* When the department determines that an overpayment exists, the case shall be referred to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

46.27(3) Rescinded IAB 2/8/89, effective 4/1/89.

46.27(4) *Change of circumstances.* When financial circumstances change, the recoupment plan is subject to revision.

46.27(5) *Collection.* Recoupment for overpayments shall be made from the parent or nonparental relative who was the caretaker relative, as defined in 441—subrule 41.22(3), at the time the overpayment occurred. When both parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

46.27(6) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the case is canceled and the amount of the overpayment is less than \$35. If the case is reopened within three years, recoupment is initiated again. Recoupment will be waived on nonfraud overpayments of less than \$35 which have been held in suspense for three years.

441—46.28(239B) Intentional program violation. Rescinded IAB 11/8/06, effective 1/1/07.

441—46.29(239B) Fraudulent misrepresentation of residence. A person convicted in a state or federal court, or in an administrative hearing, of having made a fraudulent statement or representation of the person's place of residence in order to receive assistance simultaneously from two or more states shall be ineligible for assistance for ten years. For the purpose of this rule, the term "assistance" means assistance under Titles IV-A or XIX of the Social Security Act, or the Food Stamp Act of 1977, or benefits in two or more states under the Supplemental Security Income program under Title XVI. The ten-year period begins on the date the person is convicted. The prohibition does not apply to a convicted person who is pardoned by the President of the United States, beginning with the month after the pardon is given.

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.7, and 239B.14.

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CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa Health and Wellness Plan, effective January 1, 2014, and administered by the department pursuant to 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187. Implementation of the Iowa Health and Wellness Plan is subject to approval by the Secretary of the United States Department of Health and Human Services of any waivers of the requirements of Title XIX of the Social Security Act to provide for federal funding of the plan. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.1(249A,85GA,SF446) Definitions.

“*Caretaker relative*” means a relative listed in 441—subrule 75.55(1).

“*Countable income*” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

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

“*Enrollment period*” means the 12-month period for which Iowa Health and Wellness plan eligibility is established.

“*Essential health benefits*” means the essential health benefits defined at 42 U.S.C. § 18022.

“*Federal poverty level*” means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

“*Health insurance marketplace*” or “*exchange*” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“*Iowa Health and Wellness Plan*” means the medical assistance program set forth in this chapter.

“*Iowa wellness plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Marketplace choice plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

“*Medical home*” means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient’s family; utilizes the partnership to access and integrate all medical and nonmedical health-related services across all elements of the health care system and the patient’s community as needed by the patient and the patient’s family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the following characteristics:

1. A personal provider.
2. A provider-directed team-based medical practice.
3. Whole person orientation.
4. Coordination and integration of care.
5. Quality and safety.
6. Enhanced access to health care.
7. A payment system that appropriately recognizes the added value provided to patients who have a patient-centered medical home.

“*Medically exempt individual*” means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR § 440.315 as amended on July 15, 2013.

“*Member*” means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

“*Minimum essential coverage*” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

“*Modified adjusted gross income*” means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

“*Personal provider*” means the patient’s first point of contact in the health care system with a primary care provider who identifies the patient’s health-related needs and, working with a team of health care professionals and providers of medical and nonmedical health-related services, provides for and coordinates appropriate care to address the health-related needs identified.

“*Primary care provider*” includes but is not limited to any of the following licensed or certified health care professionals who provide primary care:

1. A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.
2. An advanced registered nurse practitioner.
3. A physician assistant.
4. A chiropractor.

“*Primary medical provider*” means a personal provider trained to provide first contact and continuous and comprehensive care to a member, chosen by a member or to whom a member is assigned under the Iowa health and wellness plan as the member’s primary medical provider.

“*Qualified employer-sponsored coverage*” shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

“*Qualified health plan*” shall be defined pursuant to Section 1301 of the Patient Protection and Affordable Care Act, Public Law 111-152.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3548C, IAB 1/3/18, effective 2/7/18]

441—74.2(249A,85GA,SF446) Eligibility factors. Except as more specifically provided in this chapter, Iowa Health and Wellness Plan eligibility shall be determined according to the requirements of 441—Chapter 75.

74.2(1) Persons covered. Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa Health and Wellness Plan shall be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the federal poverty level for their household size; and
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and
- d. Are not pregnant.

74.2(2) Parents or caretakers of dependent children. All children under the age of 21 living with a parent or other caretaker relative who will be claimed as a dependent by the parent or caretaker relative for state or federal income tax purposes must be enrolled in Medicaid, in the Children’s Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent’s or other caretaker relative’s eligibility for Iowa Health and Wellness Plan benefits.

74.2(3) Citizenship. To be eligible for Iowa Health and Wellness Plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.3(249A,85GA,SF446) Application. Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa Health and Wellness Plan.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.4(249A,85GA,SF446) Financial eligibility.

74.4(1) Countable income. Individuals are financially eligible for the Iowa Health and Wellness Plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

74.4(2) Household size. For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.
[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.5(249A,85GA,SF446) Enrollment period.

74.5(1) Effective dates of eligibility. Iowa Health and Wellness Plan eligibility shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,85GA,SF446).

74.5(2) Reinstatement. Enrollment for the Iowa Health and Wellness Plan may be reinstated without a new application in accordance with 441—subrule 76.12(2).

74.5(3) Presumptive eligibility. The enrollment period of 12 consecutive months shall not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with rules 441—76.7(249A) and 441—76.13(249A).

74.5(4) Retroactive enrollment. Medical assistance shall be available to a pregnant woman or an infant (under one year of age) for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—subrule 76.13(3).
[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—74.6(249A,85GA,SF446) Reporting changes.

74.6(1) Reporting requirements. As a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.
- d. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- e. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
- f. The member's countable income increases in a manner that must be reported according to the requirements of rule 441—76.15(249A).
- g. The member is confirmed pregnant.

74.6(2) Untimely report. When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with rule 441—75.28(249A) and 441—Chapter 11. Program expenditures may include, but are not limited to, premiums and capitation payments.

74.6(3) Effective date of change. After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 16.3(1); or
 - b. The enrollment period has expired and the member is not eligible for a new enrollment period.
- [ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—74.7(249A,85GA,SF446) Reenrollment. A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—subrule 76.14(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.8(249A,85GA,SF446) Terminating enrollment. Iowa Health and Wellness Plan enrollment shall end when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the federal poverty level.
10. The member reports that she is pregnant.
11. The Iowa Health and Wellness Plan is discontinued according to the requirements in rule 441—74.14(249A,85GA,SF446).
12. The member does not pay monthly contributions as required by subrule 74.11(2).

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.9(249A,85GA,SF446) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with rule 441—75.28(249A).

74.9(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with rule 441—75.28(249A).

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.10(249A,85GA,SF446) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. A provider requesting a hearing on behalf of a member must have the prior express written consent of the member or the member's lawfully appointed guardian. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the provider submits a document providing the member's consent to the request for a state fair hearing. The document must specifically inform the member 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 member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily, and intelligently consents to the provider's bringing the state fair hearing on the member's behalf.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,85GA,SF446).

74.10(3) Coverage decisions and actions by participating marketplace choice plans must first be appealed through the plan's internal appeal process and through the external review process pursuant to Iowa Administrative Code 191—Chapter 76. After a member has exhausted the member's rights under the external review process, the member may appeal a decision or action pursuant to 441—Chapter 7. Appeal requests made pursuant to 441—Chapter 7 shall result in a change from benefits and service delivery under subrule 74.12(2) to benefits and service delivery under subrule 74.12(1). Benefits and service delivery under subrule 74.12(1) shall remain in effect for the remainder of the member's eligibility period.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15]

441—74.11(249A,85GA,SF446) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to an \$8 copayment by the member, which shall be subtracted from the Iowa Health and Wellness Plan payment otherwise due to the provider. This copayment will be waived during calendar year 2014.

74.11(2) Monthly contributions. Members enrolled in the Iowa Health and Wellness Plan with household income at or above 50 percent of the federal poverty level are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to rule 441—75.70(249A), as a percentage of the federal poverty level (FPL) for the household. Monthly contribution amounts are as follows:

- (1) For a member with household income between 50 and 100 percent of the FPL, \$5;
- (2) For a member with household income above 100 percent of the FPL, \$10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

- (1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.
- (2) The member is determined to be a medically exempt individual pursuant to subrule 74.12(3).
- (3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.
- (4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

d. Billing and payment. Form 470-5285, Iowa Health and Wellness Plan Billing Statement, shall be used for billing and collection.

(1) Method of payment. Members shall submit contribution payments to the following address: Iowa Medicaid Enterprise, Iowa Health and Wellness Plan Monthly Contributions, P.O. Box 14485, Des Moines, Iowa 50306-3485.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution for each month is due on the last calendar day of the month that the monthly contribution is to cover.

2. If the last calendar day falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department shall apply monthly contributions payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An Iowa wellness plan member who fails to pay the assessed monthly contributions and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with

rule 441—75.28(249A). A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) A marketplace choice plan member who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall have the member's eligibility terminated. In addition, the unpaid monthly contribution shall be subject to recovery in accordance with rule 441—75.28(249A) as an unpaid premium.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions must re enroll for Medicaid benefits pursuant to 441—Chapter 76.

f. Refund of monthly contributions.

(1) Monthly contributions paid for any period shall be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2) "c" or when a member's Iowa Health and Wellness Plan coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in the Iowa Health and Wellness Plan; or

2. The member dies.

(2) The amount of any refund shall be offset by any outstanding monthly contributions owed.

(3) The refund shall be paid within two calendar months.

74.11(3) Aggregate annual limits on copayments and monthly contributions. The total aggregate annual amount of copayments and monthly contributions for an individual shall not exceed 5 percent of the household's countable annual income determined pursuant to rule 441—75.70(249A).

74.11(4) Healthy behaviors. An Iowa Health and Wellness Plan member who completes a wellness examination and health risk assessment during any enrollment year shall have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

b. A health risk assessment must be one of the following:

(1) An "Assess My Health" assessment offered through the department;

(2) An assessment offered by a managed care plan through which the member is receiving Iowa Health and Wellness Plan benefits; or

(3) An assessment offered by a qualified health plan through which the member is receiving Iowa Health and Wellness Plan benefits.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—74.12(249A,85GA,SF446) Benefits and service delivery. Covered benefits and the service delivery method shall be determined by the member's countable income and health status.

74.12(1) Iowa wellness plan services. Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be a medically exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

a. Covered Iowa wellness plan services are essential health benefits, all other benefits required pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), including prescription drugs, and dental services consistent with 441—Chapter 78.

b. Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88.

c. Dental services shall be provided through a contract with one or more commercial dental plans. The department may restrict member access to those entities with which the department contracts. The

dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) Marketplace choice plan services. At the department's discretion, Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level may be enrolled in a marketplace choice plan unless the member is determined by the department to be a medically exempt individual. At the department's discretion, marketplace choice coverage may be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will be provided by the medical assistance program.

a. Upon enrollment, a member shall choose a qualified health plan from those designated by the department to provide coverage to marketplace choice plan members.

b. When the member does not select a qualified health plan pursuant to notice of the need to do so, the department will select a plan, enroll the member, and notify the member of the assigned plan.

c. The department shall pay premiums to designated qualified health plans participating on the health insurance marketplace to buy coverage for eligible marketplace choice plan members. The department shall begin payment of the member's premiums for the first month of enrollment in the qualified health plan. The qualified health plan shall provide the member with an insurance card identifying the member as an enrollee of the plan. The department shall provide the member with a medical assistance eligibility card for covered medical services not provided by the qualified health plan.

d. Covered services are all benefits, including essential health benefits, provided by the designated qualified health plan on the health insurance marketplace, including prescription drugs. Services not covered by the qualified health plan, but covered pursuant to the marketplace choice 1115 waiver or the marketplace choice state plan will be covered by the Medicaid program.

e. Dental services shall be provided through a contract with one or more commercial dental plans with covered services consistent with 441—Chapter 78. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(3) Medically exempt individuals. An Iowa Health and Wellness Plan member who has been determined by the department to be a medically exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

b. A provider with a current National Provider Identifier number, an employee of the department of human services, a designee of the department of corrections, a qualified health plan, or a mental health and disability services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5196, Medically Exempt Attestation and Referral Form.

c. Upon receipt of Form 470-5194 or 470-5196, the Iowa Medicaid enterprise shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR § 440.315 as amended on July 15, 2013.

74.12(4) Qualified employer-sponsored coverage. An individual who has access to cost-effective employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 1698C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—74.13(249A,85GA,SF446) Claims and reimbursement methodologies.

74.13(1) Claims for services not provided by a qualified health plan. Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's

qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80 or to the member’s Medicaid managed care organization.

74.13(2) *Payment for services not provided by a qualified health plan.* Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member’s qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member’s Medicaid managed care organization and the provider.

74.13(3) *Payment for services provided by the marketplace choice plan.* Payment for services provided under the marketplace choice plan shall be made in accordance with the rates filed with the Iowa insurance division.

[ARC 1135C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—74.14(249A,85GA,SF446) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa Health and Wellness Plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

[ARC 1135C, IAB 10/30/13, effective 10/2/13]

441—74.15(249A,85GA,ch138) Enrollment for IowaCare members. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

These rules are intended to implement 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187, and Iowa Code chapter 249A.

[Filed Emergency After Notice ARC 1135C (Notice ARC 0972C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]

[Filed Emergency ARC 1214C, IAB 12/11/13, effective 11/13/13]

[Filed ARC 1354C (Notice ARC 1213C, IAB 12/11/13), IAB 3/5/14, effective 4/9/14]

[Filed ARC 1698C (Notice ARC 1618C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]

[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

[Filed Emergency ARC 3353C, IAB 10/11/17, effective 10/1/17]

[Filed ARC 3548C (Notice ARC 3375C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]

[Filed ARC 3549C (Notice ARC 3355C, IAB 10/11/17), IAB 1/3/18, effective 2/7/18]

[Filed ARC 4973C (Notice ARC 4675C, IAB 9/25/19), IAB 3/11/20, effective 4/15/20]

CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.

75.1(1) *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

- a. Persons denied RCA because the amount of payment would be less than \$10.
- b. Rescinded IAB 7/30/08, effective 10/1/08.
- c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) *Persons receiving care in a medical facility who would be eligible under a special income standard.*

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
 - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
 - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A “period of 30 days” is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain “under the jurisdiction of the institution” a person must first have been physically admitted to the institution.

75.1(8) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of “essential person” in effect in the public assistance program on December 31, 1973.

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

75.1(10) *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

- (1) Failure to provide information, or
- (2) Failure to comply with other procedural requirements.

75.1(12) *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

- a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and
- b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and
- c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

75.1(14) *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

- a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed \$2,000 for applicant households or \$5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.
- b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).
- c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2) "a," "b," "c," and "d" shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1) "a" but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8) "c" and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the \$30 or the \$30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins

with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) "b" and "c," shall be treated in accordance with paragraphs 75.57(9) "b" and "c."

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed \$10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, “family” shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. “Family” also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months’ Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph “*f*” below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs “*g*” and “*i*” of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)“*f*” and 75.57(2)“*l*.”

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional

six-month period as required in paragraph 75.1(31)“h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family’s control.
4. There was a failure to receive the department’s notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client’s achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family’s average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1)“a,” including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph “g” or “i” above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person’s monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person’s resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person’s income and resources shall be determined as under the SSI program.

75.1(34) Specified low-income Medicare beneficiaries. Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) Medically needy persons.

a. Coverage groups. Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. Resources and income of all persons considered.

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. Resources.

(1) The resource limit for adults in SSI-related households shall be \$10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) “b,” “c,” “g,” “h,” and “i” regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	\$483	\$483	\$566	\$666	\$733	\$816	\$891	\$975	\$1058	\$1158

Each additional person \$116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total. The MNIL for the retroactive certification period, when applicable, shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period when applicable shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the

provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3," paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed by multiplying the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the Consumer Price Index for All Urban Consumers as published by the Bureau of Labor Statistics.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.
4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

- (1) Care in a nursing facility or an intermediate care facility for the mentally retarded.
- (2) Care in an institution for mental disease.
- (3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) Expanded specified low-income Medicare beneficiaries. As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

- a. The person is not otherwise eligible for Medicaid.
- b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.
- d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.
- e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) Home health specified low-income Medicare beneficiaries. Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) Continued Medicaid for disabled children from August 22, 1996. Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) Working persons with disabilities.

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
 - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
 - (2) They are less than 65 years of age.
 - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.
 - (4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)“c.”
 - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)“a”(1) above.
 - (6) They have paid any premium assessed under paragraph 75.1(39)“b” below.

- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of

application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$34
165% of Federal Poverty Level	\$47
180% of Federal Poverty Level	\$56
200% of Federal Poverty Level	\$66
225% of Federal Poverty Level	\$77
250% of Federal Poverty Level	\$89
300% of Federal Poverty Level	\$112
350% of Federal Poverty Level	\$137
400% of Federal Poverty Level	\$161
450% of Federal Poverty Level	\$186
550% of Federal Poverty Level	\$232
650% of Federal Poverty Level	\$280
750% of Federal Poverty Level	\$329
850% of Federal Poverty Level	\$389
1000% of Federal Poverty Level	\$467
1150% of Federal Poverty Level	\$547
1300% of Federal Poverty Level	\$631
1480% of Federal Poverty Level	\$729

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to Form 470-3902, MEPD Billing Statement.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPD Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

“*Family*,” if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, “family” includes the individual’s spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual’s family. An individual living alone or with others not listed above shall be considered to be a family of one.

“*Medical savings account*” means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

“*Retirement account*” means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) “f” as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph “a” continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph “a” shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or

- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Persons eligible for family planning services under demonstration waiver.* Rescinded IAB 10/11/17, effective 10/1/17.

75.1(42) *Medicaid for independent young adults.* Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

- a. The person is at least 18 years of age and under 21 years of age.
- b. On the person's eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.
- c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.
- d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

(1) "Household" shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person's own children;
2. The person's spouse; and
3. Any children of the person's spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person's household. A person who lives alone or with others not listed above, including the person's parents, shall be considered a household of one.

(2) The department shall determine the household's countable income pursuant to rule 441—75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) Medicaid for children with disabilities. Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

- a. The child is under 19 years of age.
- b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.
- c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.
- d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

75.1(44) Presumptive eligibility for children. Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. *Qualified entity.* A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

(1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and

(2) Has signed an agreement with the department as a qualified entity.

b. Application process. Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) “f.” The qualified entity shall use the department’s web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or hawki eligibility determination, regardless of the child’s presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or hawki eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

c. Eligibility requirements. To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household’s gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

d. Period of presumptive eligibility. Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for hawki; or

(4) The day the child is determined ineligible for Medicaid and hawki. Withdrawal of the Medicaid or hawki application before eligibility is determined shall not affect the child’s eligibility during the presumptive period.

e. Services covered. Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or hawki eligibility by the department.

75.1(45) Medicaid for former foster care youth. Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

a. The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;

b. The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but

has income that exceeds the level of income applicable under Iowa's state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

c. The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6. [ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7833B, IAB 6/3/09, effective 8/1/09; ARC 7929B, IAB 7/1/09, effective 7/1/09; ARC 7931B, IAB 7/1/09, effective 7/1/09; ARC 8095B, IAB 9/9/09, effective 10/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8261B, IAB 11/4/09, effective 10/15/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8713B, IAB 5/5/10, effective 8/1/10; ARC 8897B, IAB 6/30/10, effective 9/1/10; ARC 9581B, IAB 6/29/11, effective 8/3/11; ARC 9647B, IAB 8/10/11, effective 8/1/11; ARC 9956B, IAB 1/11/12, effective 1/1/12; ARC 0149C, IAB 6/13/12, effective 8/1/12; ARC 0579C, IAB 2/6/13, effective 4/1/13; ARC 0820C, IAB 7/10/13, effective 8/1/13; ARC 0990C, IAB 9/4/13, effective 1/1/14; ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1482C, IAB 6/11/14, effective 8/1/14; ARC 2029C, IAB 6/10/15, effective 8/1/15; ARC 2557C, IAB 6/8/16, effective 8/1/16; ARC 3094C, IAB 6/7/17, effective 8/1/17; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3354C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18; ARC 3550C, IAB 1/3/18, effective 2/7/18; ARC 3873C, IAB 7/4/18, effective 8/8/18; ARC 4574C, IAB 7/31/19, effective 9/4/19; ARC 4898C, IAB 2/12/20, effective 3/18/20]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

- (1) File a claim or submit an application for any reasonably available medical resource, and
- (2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

- a.* Physical or emotional harm to the member for whom medical resources are being sought.
- b.* Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.
[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) When the medical assistance program pays for a member's medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be

considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs

incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.
[ARC 9696B, IAB 9/7/11, effective 9/1/11; ARC 9881B, IAB 11/30/11, effective 1/4/12]

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)“a” live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is \$1500 or less per spouse.

(10) An amount, not in excess of \$1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of \$1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social

Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

- (1) That the attribution is incorrect, or
- (2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) "d" shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) "f"(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

a. Eligibility. A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

b. Definition. “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

c. Estate recovery. An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number.

75.7(1) As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

75.7(2) The requirement of subrule 75.7(1) does not apply to an individual who:

a. Is not eligible to receive a social security number;

b. Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

c. Refuses to obtain a social security number because of a well-established religious objection.

For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(3) If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories

of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) Definitions.

a. Institutions. For purposes of this rule, "institution" means an "institution" or a "medical institution" as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, "institution" also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

b. Incapable of expressing intent regarding residency. For purposes of this rule, an individual is considered to be "incapable of indicating intent regarding residency" if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;
2. Has been judged legally incompetent; or

3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

75.10(2) Determination of residency. State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency:

a. Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

b. Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

c. Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

d. Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

e. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

f. Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

g. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

h. Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

i. Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

j. Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

- (1) Intends to reside, with or without a fixed address; or
- (2) Entered with a job commitment or to seek employment, whether or not currently employed.

k. Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

l. Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2) "j."

m. Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2) "k" or "l," the state of residence is:

- (1) The state where the individual resides, with or without a fixed address; or
- (2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2) "j," with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) Definitions.

"Care and services necessary for the treatment of an emergency medical condition" means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

“*Federal means-tested program*” means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph “1,” be eligible to have payments made on the child’s behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general’s sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:
 - Deliver in-kind services at the community level, including through public or private nonprofit agencies;
 - Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources; and
 - Are necessary for the protection of life or safety.
8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.
9. Means-tested programs under the Elementary and Secondary Education Act of 1965.
10. Benefits under the Head Start Act.
11. Benefits funded through an employment and training program of the U.S. Department of Labor.

“*Qualified alien*” means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;
11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or
12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

“*Qualifying quarters*” includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II

of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) Citizenship and alienage.

a. To be eligible for Medicaid, a person must be one of the following:

- (1) A citizen or national of the United States.
- (2) A qualified alien residing in the United States before August 22, 1996.
- (3) A qualified alien under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
- (5) An alien who has been granted asylum under Section 208 of the INA.
- (6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
- (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.
- (10) A qualified alien who has resided in the United States for a period of at least five years.
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
- (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

c. Except as provided in paragraph "*f*," applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph "*b*" shall present satisfactory documentation of citizenship or nationality as defined in paragraph "*d*," "*e*," or "*i*." A reference to a form in paragraph "*d*" or "*e*" includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2) "*i*"(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or hawki benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph 75.11(2) “d,” “e,” or “i.” The retroactive months are outside the “reasonable period” during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver’s license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph “b” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2) "e"(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2) "e"(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph "d" or "e," satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph "d" or "e."

75.11(3) Deeming of sponsor's income and resources.

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income

and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8) "b" and a \$1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

b. An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

d. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

75.11(4) Eligibility for payment of emergency medical services. Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

75.12(1) Suspension. Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

a. The department is notified of the person's entry into the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person entered the institution; or

(2) Other verified notice received by the department.

b. The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

c. On the date of entry into the public institution, the person was a Medicaid member.

d. The person is eligible for medical assistance as an individual except for institutional status.

75.12(2) Coverage during suspension. While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

75.12(3) Reinstatement. The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

a. The department is notified of the person's release from the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person was released from the institution; or

(2) Other verified notice received by the department.

b. All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[ARC 9957B, IAB 1/11/12, effective 1/1/12]

441—75.13(249A) Categorical relatedness.

75.13(1) FMAP-related Medicaid eligibility. Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) SSI-related Medicaid. Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3)“b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by

multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.
- (4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Rescinded IAB 6/2/10, effective 8/1/10.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as

an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

d. The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

d. The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

- (1) Promptly notify the applicant or member that additional corroborative evidence is needed, and
- (2) Specify the type of document which is needed.

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

- (1) Advise the applicant or member how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

c. When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

- a. The individual's spouse; or
- b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

- (1) The client has a parent or child at home.
- (2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

- (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
- (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. *Ongoing personal needs allowance.* All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for

necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) Multiple pregnancy. If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) Cost of examination. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) Exceptions to coverage. This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

d. Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2)"c."

e. Children who are eligible only in a retroactive month.

75.19(2) Duration of coverage. Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Reviews of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.20(6) *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

- a. Using the standards applicable to persons who are 18 years of age or older, and
- b. Regardless of whether a review of the member's disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the HIPP program, the department shall pay for the cost of premiums, coinsurance, copayments, and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid including managed care capitation fees. Payment shall include only the cost to the Medicaid-eligible individual or household.

75.21(1) Definitions.

"Absent parent" means a noncustodial parent, or a parent who is not living with the member.

"Authorized representative" means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to 441—subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

"Capitation payment" means a monthly payment to the managed care contractor on behalf of each member for the provision of health services under the managed care entity contract. Payment is made by the department regardless of whether the member receives services during the month. The managed care capitation payment varies based on the eligible member's sex, age, and eligibility aid type.

"Cost-effective" means a determination has been made that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost.

"Cost sharing" means the member's portions of in-network health care costs not covered by an insurance plan. "Cost sharing" includes copayments, coinsurance and deductibles, which vary among health care plans.

"Custodian" means the person recognized as representing the interests of the member for Medicaid assistance. When the member reaches the age of 18 and the custodian is not used in determining Medicaid eligibility, there shall be legal documentation in place that the custodian is now the responsible person or authorized representative.

"Department" means the Iowa department of human services.

"Employer-sponsored insurance" or *"ESI"* means any health insurance plan paid for by a business on behalf of its employees.

"High-deductible health plan" or *"HDHP"* means a health insurance plan that meets the definition found in Section 223(c)(2) of the Internal Revenue Code.

"HIPP-eligible member" means a person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP. "HIPP-eligible member" is also referred to as HIPP enrollee.

"Household" means the group of people who are used in the budgeting and size when determining Medicaid eligibility.

"Individual plan" means an insurance plan purchased through a government-run health insurance marketplace or through a local broker or agent.

“Insurance plan” means major medical comprehensive health coverage provided through an employer, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a government-run health insurance marketplace, or a local broker or agent. Dental and vision plans are not considered to be insurance plans for purposes of this definition.

“Member” means an individual who has been determined eligible for Medicaid assistance and is enrolled to receive assistance.

“Policyholder” means the person in whose name an insurance policy is registered.

“Responsible person” means an individual recognized by the department pursuant to 441—subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“Wrap benefits” means the services covered under the Medicaid state plans that are not paid for by insurance plans (i.e., waiver services, transportation).

75.21(2) Insurance plans. Participation in an insurance plan is not a condition of Medicaid eligibility. The department shall pay for the cost of the insurance plan premiums, coinsurance, copayment, and deductibles of an insurance plan for a member if:

- a. A member is enrolled in or can be added to the insurance plan; and
- b. The insurance plan is cost-effective as defined in subrule 75.21(3).

75.21(3) Cost-effectiveness. An insurance plan shall be considered cost-effective when the amount the department would pay for the member’s insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid including managed care capitation fees. When determining the cost-effectiveness of an insurance plan, the following data shall be considered:

- a. The cost to the member or household for the insurance premium, coinsurance, copayments and deductibles. No costs paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.
- b. The cost of care through Medicaid including managed care capitation fees the department would pay for the member.
- c. The estimated cost of wrap benefits per member based on the member’s sex, age, and eligibility aid type.
- d. The specific health-related circumstances of the members covered under the health plan.

Form 470-2868, HIPP Medical History Questionnaire, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result prospectively in higher-than-average bills for any Medicaid member:

(1) If the member is currently covered by the insurance plan, the department shall request from the policyholder, or the responsible person for the member, an insurance summary of the member’s paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the insurance plan. The cost of the insurance plan premium, member’s cost sharing, and administrative cost are compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, fee-for-service paid Medicaid claims may be used to project the cost-effectiveness of the plan.

- e. Annual administrative expenditures of \$150 per HIPP member covered under the health plan.
- f. Whether the estimated savings to the department for members covered under the health insurance plan is at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members. When an insurance plan is determined to be cost-effective, the department shall pay for insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the insurance plan in order to obtain coverage for the Medicaid-eligible family members. However:

- a. The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness; and

b. Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) Insurance plans ineligible for reimbursement. Premiums shall not be paid for insurance plans under any of the following circumstances:

- a.* The insurance plan is that of an absent parent.
- b.* The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).
- c.* The insurance plan is a school plan offered on the basis of attendance or enrollment at the school.
- d.* The insurance premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the insurance premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.
- e.* The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).
- f.* The persons covered under the insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.
- g.* The person is eligible only for a coverage group that does not provide full Medicaid services.
- h.* Insurance coverage is provided through the health insurance plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.
- i.* Insurance on the member(s) is maintained by someone who does not live with the member(s), is not the legal guardian of the member(s), is not a responsible person, or does not have legal permission to access the Medicaid information of the member(s) (e.g., self-supporting adult children).
- j.* The member has Medicare. If other members in the household are covered by the insurance plan, cost-effectiveness is determined without including the Medicare-covered member.
- k.* The insurance plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).
- l.* The health plan pays secondary to another plan.
- m.* The only Medicaid member is in foster care.
- n.* The member is active for Medicaid under Medicaid for children with disabilities (i.e., Medicaid for kids with special needs (MKSNI)), pursuant to subrule 75.1(43). Any other Medicaid members in the household who are covered by the health plan shall be determined for cost-effectiveness.
- o.* The insurance plan is limited due to preexisting conditions.
- p.* The insurance plan is a subsidized insurance plan purchased through a government-run health insurance exchange.
- q.* On the date the decision regarding eligibility for the HIPP program is made, the insurance is no longer available.
- r.* The insurance plan is an HDHP.

75.21(6) Department evaluation of ESI plans. When evaluating ESI plans available through an employer, if there is more than one cost-effective insurance plan available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) Effective date of premium payment. The effective date of premium payments for a cost-effective health plan shall be determined as follows:

- a.* Premium payments shall begin the later of:
 - (1) The first day of the month in which Form 470-2844, Employer's Statement of Earnings; Form 470-2875, Health Insurance Premium Payment (HIPP) Program Application; or Form H301-1, the automated HIPP referral; is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the insurance plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income for determining client participation or the amount of the spenddown obligation.

e. Form 470-3036, Employer Verification of Insurance Coverage, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage of an insurance plan not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(8) Method of premium payment. Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier, the COBRA administrator, or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment; or

(2) The department pays for only part of the total premium.

75.21(9) Payment of claims. Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(10) Reviews of cost-effectiveness and eligibility. Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. Annual review of ESI cost-effectiveness and eligibility shall be completed using Form 470-3016, Health Insurance Premium Payment (HIPP) Program Review.

b. Annual review of individual health plan cost-effectiveness and eligibility shall be completed using Form 470-3017, HIPP Private Policy Review.

c. Failure of the household to cooperate in the annual review process shall result in cancellation of premium payment.

d. Redeterminations shall be completed whenever:

(1) A premium rate, copayment, deductible, or coinsurance changes;

(2) A person covered under the policy loses full Medicaid eligibility;

(3) Changes in employment or hours of employment affect the availability of an insurance plan;

(4) The insurance carrier changes;

(5) The policyholder leaves the Medicaid home;

(6) There is a decrease in the services covered under the policy; or

(7) The Medicaid category of coverage changes.

e. The policyholder shall report changes that may affect the availability of the insurance plan reimbursed by the HIPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)“*a*,” shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of COBRA.

(1) Form 470-3037, Employer Verification of COBRA Eligibility, may be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(11) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) *Notices.*

a. Adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The insurance plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide timely and adequate notice as defined in rule 441—16.3(17A) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the insurance plan is no longer cost-effective; or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the HIPP program.

75.21(13) *Rate refund.* The department shall be entitled to any rate refund made when the insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) *Reinstatement of HIPP eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the insurance plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the policyholder’s failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(15) *Amount of insurance premium paid.*

a. For ESI plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the cost-effective members of the household.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the cost-effective members covered by the plan.

c. For insurance plans, if another household member must be covered to obtain coverage for the members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(16) *Reporting changes.* Failure to report and verify changes may result in cancellation of HIPP benefits.

a. The policyholder shall verify changes by providing a pay stub, a summary of benefits and coverage, a rate sheet, or a letter from the insurance carrier reflecting the change.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

d. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

75.21(17) Discontinuation of premium payments.

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the insurance plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility for the HIPP program, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 3493C, IAB 12/6/17, effective 1/10/18; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, “AIDS” and “HIV” are defined in accordance with Iowa Code section 141A.1.

75.22(1) Conditions of eligibility. The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician’s statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician’s statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person’s current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician’s Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

- (1) Unobligated cash.

- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) Application process.

a. *Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. *Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. *Eligible on the day of decision.* No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. *Waiting list.* After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) Presumed eligibility The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) Family coverage. When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) Method of premium payment. Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

75.22(6) Effective date of premium payment. Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) Reviews. The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium

Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) Termination of assistance. Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

- a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).
- b. The insurance coverage is no longer available.
- c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.
- d. Funding appropriated for the program is exhausted.
- e. The person with AIDS or an HIV-related illness dies.
- f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) Notices.

a. An adequate notice as defined in 441—subrule 16.3(2) shall be provided under the following circumstances:

- (1) To inform the applicant of the initial decision regarding eligibility to participate in the program.
- (2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in rule 441—16.3(17A) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) Confidentiality. The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) Ineligibility for services. When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. *Institutionalized individual.* When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

c. Client participation after period of ineligibility. Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

75.23(2) Look-back date.

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) Period of ineligibility. The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. Current average statewide costs shall be published on the department's website.

75.23(4) Reduction of period of ineligibility. The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) Exceptions. An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.
(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.
(2) From the individual's spouse to another for the sole benefit of the individual's spouse.
(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

2. Household goods.

3. A vehicle required by the client for transportation.

4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) Assets held in common. In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"*Assets*" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"*Income*" shall be defined by 42 U.S.C. Section 1382a.

"*Institutionalized individual*" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"*Resources*" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"*Transfer or disposal of assets*" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) "b"(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) "c");
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) "d"); or
6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

a. The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9) "b" and also meets the condition described in paragraph 75.23(9) "c."

b. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) "a" must meet one of the following conditions:

- (1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.
- (2) The annuity is purchased with proceeds from:
 1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;
 2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or
 3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

- (3) The annuity:
1. Is irrevocable and nonassignable;
 2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and
 3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

c. To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9) “a” must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:

- (1) In the first position; or
- (2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

d. The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:

- (1) In the first position; or
- (2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual’s application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

- (1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).
- (2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.
- (3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

- (1) The note, loan, or mortgage was purchased before February 8, 2006; or
- (2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9) “a” were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual’s home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual’s home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

- (1) The life estate was purchased before February 8, 2006; or
- (2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 3/9/11, effective 5/1/11; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16; ARC 3183C, IAB 7/5/17, effective 7/1/17; ARC 3869C, IAB 7/4/18, effective 7/1/18; ARC 4572C, IAB 7/31/19, effective 7/11/19]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) Establishment of trust.

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

- (1) The purposes for which a trust is established.
- (2) Whether the trustees have or exercise any discretion under the trust.
- (3) Any restrictions on when or whether distribution may be made for the trust.
- (4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) Treatment of revocable and irrevocable trusts.

a. In the case of a revocable trust:

- (1) The principal of the trust shall be considered an available resource.
- (2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.
- (3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) Exceptions. This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts

remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual. For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates are updated annually and shall be published on the department's website.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

- (1) The trust is established and managed by a nonprofit association.
- (2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- (3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

This rule is intended to implement Iowa Code section 249A.4.
 [ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0822C, IAB 7/10/13, effective 7/1/13; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 1483C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16; ARC 3182C, IAB 7/5/17, effective 7/1/17; ARC 3183C, IAB 7/5/17, effective 7/1/17; ARC 3869C, IAB 7/4/18, effective 7/1/18; ARC 3870C, IAB 7/4/18, effective 7/1/18; ARC 4572C, IAB 7/31/19, effective 7/1/19]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“Aged” shall mean a person 65 years of age or older.

“Applicant” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Blind” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“Break in assistance” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“Central office” shall mean the state administrative office of the department of human services.

“Certification period” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“Client” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“CMAP-related medically needy” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“Community spouse” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“Conditionally eligible” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown

amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“Coverage group” shall mean a group of persons who meet certain common eligibility requirements.

“Department” shall mean the Iowa department of human services.

“Disabled” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“FMAP-related medically needy” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“Health insurance” shall mean protection which provides payment of benefits for covered sickness or injury.

“Incurred medical expenses” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or the certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“Institutionalized person” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“Institutionalized spouse” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“Local office” shall mean the county office of the department of human services or the mental health institute or hospital school.

“Medically needy income level (MNIL)” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“Member” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“Necessary medical and remedial services” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

“Noncovered Medicaid services” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“Nursing facility services” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“Obligated medical expense” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“Ongoing eligibility” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“Pay and chase” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“Payee” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“Recertification” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“*Recipient*” shall mean a person who is receiving assistance including receiving assistance for another person.

“*Responsible relative*” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“*Retroactive certification period*” for medically needy shall mean one, two, or three calendar months prior to the date of application, as provided in 441—subrule 76.13(3). The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“*Retroactive period*” shall mean the three or fewer calendar months immediately preceding the month in which an application is filed, pursuant to 441—subrule 76.13(3).

“*Spenddown*” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“*SSI-related*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“*SSI-related medically needy*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“*Supply*” shall mean the requested information is received by the department by the specified due date.

“*Transfer of assets*” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“*Unborn child*” shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18; ARC 4208C, IAB 1/2/19, effective 2/6/19]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28(249A) Recovery.

75.28(1) Definitions.

“*Administrative overpayment*” means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

“*Agency error*” means medical 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 department.
6. Failure to make prompt revisions in medical payment following changes in policies requiring the changes as of a specific date.

“*Client*” means a current or former Medicaid member.

“*Client error*” means medical 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. “*Client error*” 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—76.15(249A).

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

“*Premiums paid for medical assistance*” means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

75.28(2) Amount subject to recovery. The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

75.28(3) Notification. All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures shall include:

- (1) For whom assistance was paid;
- (2) The period during which assistance was incorrectly paid;
- (3) The amount of assistance subject to recovery; and
- (4) The reason for the incorrect expenditure.

b. Notification of unpaid premiums shall include:

- (1) The amount of the premium; and
- (2) The month covered by the medical assistance premium.

75.28(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 may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

75.28(5) Repayment. The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for persons with an intellectual disability, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

75.28(6) Appeals. The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

75.28(7) Estate recovery. Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member’s surviving spouse, or the estate of the member’s surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2) “*d.*” The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definitions.

“*Capitated payment/rate*” means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

“*Estate.*” For the purpose of this subrule, the “estate” of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

b. Debt due for member 55 years of age or older. Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member’s estate upon the member’s death for all medical assistance provided on the member’s behalf on or after July 1, 1994.

c. Debt due for member under the age of 55 in a medical institution.

(1) Receipt of medical assistance creates a debt due to the department from the member’s estate upon the member’s death for all medical assistance provided on the member’s behalf on or after July 1, 1994, when the member:

1. Is under the age of 55; and
2. Is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute; and
3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member’s behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

d. Request for a determination of ability to return home. Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member’s behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member’s ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

e. Determination of ability to return home. When the member or someone acting on the member’s behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member’s representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member’s representative asks for a reconsideration of the decision.

The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

f. Debt collection.

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of the debt.

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as being under the family investment program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

h. Amount waived. If collection of all or part of a debt is waived pursuant to paragraph 75.28(7) "g," to the extent that the person received the member's estate, the amount waived shall be a debt due from the following:

(1) The estate of the member's surviving spouse, upon the death of the spouse.

(2) The estate of the member's surviving child who is blind or has a disability, upon the death of the child.

(3) A surviving child who was under 21 years of age at the time of the member's death, when the child reaches the age of 21.

(4) The estate of a surviving child who was under 21 years of age at the time of the member's death, if the child dies before reaching the age of 21.

(5) The hardship waiver recipient, when the hardship no longer exists.

(6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

i. Impact of asset disregard on debt due. The estate of a member who is eligible for medical assistance under subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid

on behalf of the member before these conditions shall be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child's reaching the age of 21.

k. Reimbursement to county. If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department shall reimburse the county on a proportionate basis.

[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—75.29(249A) Investigation by quality control or the department of inspections and appeals. An applicant or member shall cooperate with the department when the applicant's or member's case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person's eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

441—75.30(249A) Member lock-in. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

441—75.31 to 75.49 Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“Applicant” shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Application period” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“Assistance unit” includes any person whose income is considered when determining eligibility.

“Bona fide offer” means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

“Central office” shall mean the state administrative office of the department of human services.

“Change in income” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“Change in work expenses” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“Department” shall mean the Iowa department of human services.

“Dependent” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Dependent child” or *“dependent children”* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

“Income in-kind” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“Initial two months” means the first two consecutive months for which eligibility is granted.

“Medical institution,” when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

“Needy specified relative” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“Nonrecurring lump sum unearned income” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

“Parent” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“Prospective budgeting” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

“Recipient” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“Schedule of needs” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

“Stepparent” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

“Unborn child” shall include an unborn child during the entire term of the pregnancy.

“Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Rescinded IAB 2/10/10, effective 3/1/10.

441—75.52(249A) Continuing eligibility.

75.52(1) Reviews. Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

75.52(2) Additional reviews. A redetermination of specific eligibility factors shall be made when:

- a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or
- b. A change in the member’s circumstances comes to the attention of a staff member.

75.52(3) Forms.

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

75.52(4) Client responsibilities. For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) "f" and 75.57(2) "l."

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

- (1) Income from all sources, including any change in care expenses.
- (2) Resources.
- (3) Members of the household.
- (4) School attendance.
- (5) A stepparent recovering from an incapacity.
- (6) Change of mailing or living address.
- (7) Payment of child support.
- (8) Receipt of a social security number.
- (9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8) "b."
- (10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

- (1) Members of the household.
- (2) Change of mailing or living address.
- (3) Sources of income.
- (4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

- (1) A person enters or leaves the household.
- (2) The mailing or living address changes.
- (3) A source of income changes.
- (4) A health insurance premium or coverage change is effective.
- (5) Of any change in income.
- (6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4) “c” through “e,” any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4) “c” through “e.”

75.52(5) Effective date. After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—16.3(17A) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—16.3(17A).

[ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) Definition of resident. A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) Retention of residence. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) Suitability of home. The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) Absence from the home.

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “b.”

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician’s statement. Failure to return within one year from the date of entry into the medical institution will result in the individual’s needs being removed from the eligible group.

(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1) "b" as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, "education or training" means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4) "b"(1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

[ARC 0579C, IAB 2/6/13, effective 4/1/13]

441—75.54(249A) Eligibility factors specific to child.

75.54(1) Age. Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) Residing with a relative. The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) Deprivation of parental care and support. Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) Continuous eligibility for children. Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) Specified relationship.

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1)“e.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)“c” reserved for the current or future month’s income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group’s property is within the reserve defined in paragraph “e.”

o. Nonhomestead property that produces income consistent with the property’s fair market value.

75.56(2) Persons considered.

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) Homestead defined. The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) Liquidation. When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) Net market value defined. Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) Availability.

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

75.56(7) Damage judgments and insurance settlements.

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) Conservatorships.

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)“*e*” and 75.24(2)“*b*.”

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)“*e*,” 75.57(6)“*u*,” and 75.57(7)“*o*.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

75.57(1) Unearned income. Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“*b*” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“*c*” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2) "a" and "b" and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9) "a"(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family-life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) Shared living arrangements. When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) Diversion of income.

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the

difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the food assistance program benefit.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

- k.* Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
 - l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
 - m.* The income of a supplemental security income recipient.
 - n.* Income of an ineligible child.
 - o.* Income in-kind.
 - p.* Family support subsidy program payments.
 - q.* Grants obtained and used under conditions that preclude their use for current living costs.
 - r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
 - s.* Subsidized guardianship program payments.
 - t.* Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
 - u.* The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
 - v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
 - (1) The loan is obtained from an institution or person engaged in the business of making loans.
 - (2) There is a written agreement to repay the money within a specified time.
 - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
 - w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
 - x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
 - y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
 - z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."
 - aa.* Payments received from the Radiation Exposure Compensation Act.
 - ab.* Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.
- 75.57(7) Exempt as income.** The following are exempt as income.
- a.* Reimbursements from a third party.
 - b.* Reimbursement from the employer for a job-related expense.

- c.* The following nonrecurring lump sum payments:
- (1) Income tax refund.
 - (2) Retroactive supplemental security income benefits.
 - (3) Settlements for the payment of medical expenses.
 - (4) Refunds of security deposits on rental property or utilities.
 - (5) That part of a lump sum received and expended for funeral and burial expenses.
 - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d.* Payments received by the family for providing foster care when the family is operating a licensed foster home.
- e.* A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.
- When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- f.* Federal or state earned income tax credit.
- g.* Supplementation from county funds, providing:
- (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
 - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- h.* Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- i.* A retroactive corrective family investment program (FIP) payment.
- j.* The training allowance issued by the division of vocational rehabilitation, department of education.
- k.* Payments from the PROMISE JOBS program.
- l.* The training allowance issued by the department for the blind.
- m.* Payments from passengers in a car pool.
- n.* Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o.* Rescinded IAB 10/4/00, effective 10/1/00.
- p.* Rescinded IAB 10/4/00, effective 10/1/00.
- q.* Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r.* Rescinded IAB 10/4/00, effective 10/1/00.
- s.* Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.
- t.* Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.
- u.* Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1) "b"(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.
- EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.
- v.* Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8) "c" effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.
- w.* Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3) "b" shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4) "b" and 75.57(1) "d."

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.

a. *Treatment of income in excluded parent cases.* A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) “a,” “b,” and “c,” and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. *Treatment of income in stepparent cases.* The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent’s monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent’s ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) “b”(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) “b”(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent’s dependents living in the home, when the dependents’ needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) “b”(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) “a”(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1) “f.”

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related

Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)“b”(1) through (7). Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)“b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) Budgeting process.

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4) "d" and "e" is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4) "c" is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9) "i."

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8) "b" and "c," shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)“b,” shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) Restriction on diversion of income. Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 8556B, IAB 3/10/10, effective 2/10/10; ARC 9043B, IAB 9/8/10, effective 11/1/10]

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

- (1) All dependent children who are siblings of whole or half blood or adoptive.
- (2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

- (1) The needy specified relative who assumes the role of parent.
- (2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

- a.* The definitions of the basic need components are as follows:
- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
 - (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
 - (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
 - (4) Food: Including school lunches.
 - (5) Clothing: Including layette, laundry, dry cleaning.
 - (6) Personal care and supplies: Including regular school supplies.
 - (7) Medicine chest items.
 - (8) Communications: Telephone, newspapers, magazines.
 - (9) Transportation: Including bus fares.
- b.* Special situations in determining eligible group:
- (1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) Exclusions from the eligible group. In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

- a. Siblings (of whole or half blood, or adoptive) of eligible children.
- b. Self-supporting parents of minor unmarried parents.
- c. Stepparents of eligible children.
- d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

441—75.61 to 75.69 Reserved.

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI). Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using "modified adjusted gross income" (MAGI) and "household income" pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing.

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441—75.71(249A) Income limits. Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program and Child Medical Assistance Program	441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931	1	\$447
		2	\$716
		3	\$872
		4	\$1,033
		5	\$1,177
		6	\$1,330
		7	\$1,481
		8	\$1,633
		9	\$1,784
		10	\$1,950
			over 10
Mothers and Children, for pregnant women and for infants under one year of age	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		375% of the federal poverty level for the household
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		167% of the federal poverty level for the household
Medicaid for Independent Young Adults	441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)		254% of the federal poverty level for the household

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These rules are intended to implement Iowa Code section 249A.4.

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⁰ Two or more ARCs

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CHAPTER 76
ENROLLMENT AND REENROLLMENT

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/1/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter specifies the process for enrolling and reenrolling in the Iowa Medical Assistance or “Medicaid” program and addresses related matters.

Eligible individuals must be enrolled for the date on which services are provided in order for payment to be made for the services received.

Initial enrollment must be based on an application submitted to the department, a referral from a health insurance marketplace, an express lane eligibility determination, a Social Security Income eligibility determination, a transmittal from the federal Social Security Administration for Medicare savings programs, or a presumptive eligibility determination, as described in rules 441—76.2(249A) through 441—76.7(249A).

Reenrollment is based on a review, as described in rule 441—76.14(249A), of all eligibility factors under 441—Chapter 75.

Applicants and members are required to report changes pursuant to rule 441—76.15(249A).

Department action on information received will occur as described in rules 441—76.15(249A) and 441—76.16(249A).

Automatic redeterminations of eligibility will occur as described in rule 441—76.17(249A).

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.1(249A) Definitions.

“*Authorized representative*” means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

“*Electronic account*” means a web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

“*Electronic case record*” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid eligibility and enrollment.

“*Health insurance marketplace*” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“*Medicare savings program*” refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are qualified disabled and working people (QDWP) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(ii), qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(i), specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iii), and expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. § 1396a(a)(10)(E)(iv).

“*Member*” means an individual who has been determined eligible for medical assistance pursuant to 441—Chapter 75 and has been enrolled to receive assistance. For the medically needy program, “member” shall mean an individual who has been determined eligible for medical assistance under the medically needy program, has been enrolled, and has countable income at or below the medically needy income level (MNIL) or has reduced countable income to the MNIL during the certification period through spenddown.

“Modified adjusted gross income” means the methodology to determine income eligibility prescribed by 1902(e)(14) of the Social Security Act (42 U.S.C. § 1396a(e)(14)).

“Presumptive eligibility” means that a person is presumed to be eligible on a temporary basis based on information provided.

“Qualified entity” is an entity that is described in Paragraphs (1) through (10) of 42 CFR 435.1101 relating to coverage groups for children, 42 CFR 435.1110b relating to hospitals determining eligibility, U.S.C. § 1396r-1 relating to coverage groups for pregnant women, or 42 U.S.C. § 1396r-1b relating to the breast and cervical cancer coverage group, that has been determined by the department to be capable of making presumptive Medicaid eligibility determinations, and that has signed an agreement with the department as a qualified entity.

“Responsible person” means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“Supplemental security income” or *“SSI”* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

“WIC” is the Special Supplemental Nutrition Program for Women, Infants, and Children established by 42 U.S.C. § 1786.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.2(249A) Application with the department. This rule describes the process of applying for medical assistance directly with the department of human services.

76.2(1) Application for eligibility effective prior to January 1, 2014. Application for the Medicaid or HAWK-I program to be initially effective prior to January 1, 2014, must be made as provided in this subrule.

a. Forms.

(1) An application for family medical assistance-related Medicaid programs shall be submitted on Health and Financial Support Application, Form 470-0462 or Form 470-0462(S); Health Services Application, Form 470-2927 or Form 470-2927(S); HAWK-I Application, Comm. 156; or HAWK-I Electronic Application Summary and Signature Page, Form 470-4016.

(2) An application for SSI-related Medicaid shall be submitted on Health Services Application, Form 470-2927 or Form 470-2927(S), or Health and Financial Support Application, Form 470-0462 or Form 470-0462(S).

(3) An application for Medicaid for persons in foster care shall be submitted on Health Services Application, Form 470-2927 or Form 470-2927(S).

b. Who can file. An application may be filed by the applicant, an adult in the applicant’s household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

c. How and where to file.

(1) An application may be filed over the Internet at www.dhs.iowa.gov, by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by fax or by email.

(2) Health Services Application, Form 470-2927 or Form 470-2927(S), may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

(3) An application for HAWK-I may be filed with the third-party administrator as provided at 441—subrule 86.3(3).

d. Minimum application requirements. A valid application is an application containing a legible name, a legible address, and a signature. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant’s behalf. Electronic and handwritten

signatures transmitted via electronic transmissions are acceptable. An application that does not include a legible name, a legible address, and a signature will be rejected without a determination of eligibility.

e. Interviews.

(1) The department may require a face-to-face or telephone interview with adult applicants, authorized representatives, or responsible persons.

(2) The department shall notify the applicant, authorized representative, or responsible person of the date, time and method of an interview. This notice shall be provided to the applicant, authorized representative, or responsible person personally, by telephone, by email, by mail or by fax.

(3) Failure of the applicant, authorized representative, or responsible person to attend a scheduled interview shall be a basis for denial of an application or cancellation of assistance for adults. Failure to attend an interview shall not serve as a basis for denial of an application or cancellation of assistance for children.

f. Additional information or verification needed to determine eligibility. The department shall notify the applicant, authorized representative, or responsible person in writing that additional information or verification is required to establish eligibility. This notice shall be provided to the applicant, authorized representative, or responsible person personally or by mail or fax.

(1) The department shall allow the applicant, authorized representative, or responsible person ten calendar days to supply the information or verification requested.

(2) The department may extend the deadline for a reasonable period of time when the applicant, authorized representative, or responsible person is making every effort but is unable to secure the required information or verification.

(3) The application shall be denied if the department does not receive one of the following by the due date:

1. The information or verification,
2. An authorization for the department to obtain the information or verification, or
3. A request for an extension of the due date.

(4) If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information or verification were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant, authorized representative, or responsible person shall have until the next business day to provide the information.

76.2(2) *Application for eligibility effective on or after January 1, 2014.* Application for the Medicaid or HAWK-I program to be initially effective on or after January 1, 2014, must be made as provided in this subrule.

a. Form. Application for the Medicaid or HAWK-I program shall be submitted on Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

b. Who can file. An application may be filed by the applicant, an adult in the applicant's household or family, an authorized representative recognized pursuant to subrule 76.9(2), or a responsible person recognized pursuant to subrule 76.9(1).

c. How and where to file.

(1) An application may be filed over the Internet at www.dhs.iowa.gov or at www.dhsservices.iowa.gov or at the health insurance marketplace website at www.healthcare.gov, by submission to any local office of the department, or by submission to a department outstation at a disproportionate share hospital, federally qualified health center, or other facility where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1-855-889-7985, or by email or fax. Addresses, email addresses and fax numbers of local offices of the department are available at www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html.

(2) An application may also be filed at the office of a qualified entity for presumptive Medicaid eligibility determinations, a WIC office, a maternal health clinic, or a well child clinic.

d. Minimum application requirements. Initial applications must be signed under penalty of perjury. An authorized representative or responsible person recognized pursuant to rule 441—76.9(249A) may sign on an applicant's behalf. Electronic, including telephonically recorded,

signatures and handwritten signatures transmitted via any electronic transmission are acceptable. An application that does not include a signature under penalty of perjury will be rejected without a determination of eligibility.

e. Additional information or verification needed to determine eligibility. The applicant must provide additional information or verification as requested by the department, including information or verification necessary to determine SSI-related Medicaid eligibility, as requested on SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

f. Interviews. The applicant, authorized representative, or responsible person may be required to attend a face-to-face or telephone interview to clarify information or to resolve conflicting information. Failure to attend a required interview will result in denial of the application.

76.2(3) Date of filing.

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1) “c” or 76.2(2) “c.” When an application is delivered after business hours, it will be considered received on the next business day.

b. A valid application for Medicaid which is filed at a WIC office, a well child clinic, a maternal health clinic, an outstationed office, or the office of a qualified entity for presumptive Medicaid eligibility determinations shall be considered filed on the date it is received and date-stamped in one of those offices. When the application is received while the office is closed, it will be considered received on the next business day.

[ARC 1069C, IAB 10/2/13, effective 10/1/13; ARC 3354C, IAB 10/11/17, effective 10/1/17; ARC 3550C, IAB 1/3/18, effective 2/7/18]

441—76.3(249A) Referrals from a health insurance marketplace. Upon receipt of a referral from a health insurance marketplace indicating that an application filed with the health insurance marketplace has been screened and that the applicant has been found to be potentially eligible for Medicaid or HAWK-I, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The applicant is required to cooperate as described in this chapter for applications received directly by the department.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. § 1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department shall rely on a determination of the child’s eligibility for food assistance pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.1(28) except for citizenship or alienage requirements, unless:

a. The child’s household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in food assistance eligibility since that time, or

c. The household’s income as calculated by the food assistance program exceeds the income limit for the mothers and children coverage group found at 441—subparagraph 75.1(28) “a”(1).

76.4(2) To obtain express lane enrollment for a child, the child’s household must request medical assistance for the child on Express Lane Medicaid for Children, Form 470-4851 or Form 470-4851(S). The department shall send Form 470-4851 or Form 470-4851(S) to the household when a child eligible for express lane enrollment is approved for food assistance pursuant to 441—Chapter 65. An adult member of the child’s household or a child receiving food assistance as head of household must sign Form 470-4851 or Form 470-4851(S) and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child's food assistance effective date. Express lane eligibility begins on the first day of the month of the child's food assistance effective date.

76.4(5) After the initial express lane enrollment, all redeterminations of medical assistance eligibility shall be made without reliance on any food assistance eligibility determination.

76.4(6) Retroactive enrollment is available pursuant to subrule 76.13(3) for any of the three months before the month of the child's food assistance effective date when the child was an infant (under the age of one) during any of the three months and the child:

- a. Has medical bills for covered services that were received in that period; and
- b. Would have been eligible for medical assistance benefits in the month services were received if the application for medical assistance had been made in that month and the eligibility determination was made without regard to food assistance eligibility.

[ARC 1069C, IAB 10/2/13, effective 10/1/13; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18]

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the Social Security Administration indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient shall be required to complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS), when additional information is necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information on this form.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.6(249A) Referral for Medicare savings program. Referrals received from the federal Social Security Administration pursuant to 42 U.S.C. 1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date on which the referral is transmitted by the Social Security Administration shall be treated as the date of application. When requested to do so, the applicant must complete Medicare Savings Programs Additional Information Request, Form 470-4846, to provide additional information needed to determine Medicare savings program eligibility.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.7(249A) Presumptive eligibility. Individuals may be temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity pursuant to this rule.

76.7(1) *For eligibility effective prior to January 1, 2014.*

a. Applicants for presumptive eligibility for children will complete Application: Presumptive Health Care Coverage for Children, Form 470-4855 or 470-4855(S).

b. Applicants for presumptive eligibility for pregnant women or for presumptive eligibility for breast and cervical cancer coverage group shall complete Health Services Application, Form 470-2927 or Form 470-2927(S).

76.7(2) *For eligibility effective on or after January 1, 2014.* Applicants for presumptive eligibility will complete Application for Health Coverage and Help Paying Costs, Form 470-5170 or 470-5170(S).

76.7(3) *How and where to file.* Applications for presumptive eligibility are filed at the office of a qualified entity for presumptive Medicaid eligibility determinations.

76.7(4) *Enrollment.* An individual is enrolled on the date that presumptive eligibility is determined by the qualified entity.

76.7(5) *Notice and appeal rights.* Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

76.7(6) *Full medical assistance eligibility determination.* All presumptive eligibility applications shall receive a full determination of eligibility for Medicaid or HAWK-I except for breast and cervical cancer and pregnant women coverage groups.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.8(249A) Applicant responsibilities.

76.8(1) *Accurate information.* Applicants are responsible to give complete and accurate information needed to establish eligibility.

76.8(2) *Time frames for providing information or verification.* Applicants shall have ten calendar days to supply the information or verification requested by the department.

76.8(3) *Extensions.* The applicant may request an extension of a reasonable period of time when the applicant is making every effort but is unable to secure the required information or verification.

76.8(4) *Failure to comply.* An application shall be denied if the applicant does not attend a required interview, if applicable under subrule 76.2(1) or 76.2(2), or if the department does not receive one of the following by the due date:

- a. The information or verification,
- b. An authorization to obtain the information or verification, or
- c. A request for an extension of the due date.

76.8(5) *Grace period.* If benefits are denied for failure to provide information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the next business day to provide the information.

76.8(6) *Referrals to the Social Security Administration.* When an applicant or member may be eligible for benefits from the Social Security Administration and is directed by the department to apply for such benefits, the applicant or member must make application for such benefits as described in rule 441—75.3(249A).

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) *Responsible person.* If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member. Except as provided in paragraph 76.9(1) "a" below, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an authorized representative as provided for in subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

a. When there is no person as described above to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes Inability to Find a Responsible Person, Form 470-3356, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

b. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

c. Copies of all departmental correspondence with the applicant or member shall be provided to the recognized responsible person.

76.9(2) *Authorized representative.* An individual or organization designated by a competent applicant or member, designated by a responsible person recognized pursuant to subrule 76.9(1), or with other legal authority to do so may act on behalf of the applicant or member in the application process, renewal of eligibility, or for ongoing eligibility.

a. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant or member or the responsible person.

The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's behalf, complete and submit a renewal form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

b. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

c. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the Internet website, www.dhsservices.iowa.gov, by mail, by email, by fax, or in person.

d. For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by fax or other electronic transmission.

e. If the authorization indicates the time period or dates the authorization is to cover, the stated period or dates shall be honored and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization. If the authorization does not indicate the time period or dates it is to cover, the authorization shall be valid for any applications filed within 120 days from the date the authorization was signed and for all subsequent actions pertaining to the applications filed within the 120-day period.

f. The power to act as an authorized representative based on a designation by an applicant, member, or responsible person is valid until the applicant, member, or responsible person modifies the authorization or notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the applicant's, member's, responsible person's, or authorized representative's signature as appropriate.

g. Copies of all departmental correspondence shall be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

b. A provider or staff member or volunteer of an organization serving as an authorized representative or responsible person must sign an agreement that the provider, staff member, or volunteer will adhere to the regulations in Part 431, Subpart F of 42 CFR Chapter IV and at 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

c. The authorized representative or responsible person is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible person represents.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate if notices and other communications are to be provided by the department in an electronic format through the individual's electronic account, rather than by regular mail. The applicant may change the selection at

any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an email to the individual notifying the individual of the notice or other communication.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.12(249A) Application not required.

76.12(1) Adding a new person.

a. Adding an eligible person. For members whose eligibility is based on the modified adjusted gross income methodology, a new application is not required when an eligible person is added to an existing Medicaid-eligible group. Such a person is considered to be included in the application that established the existing eligible group. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date of entry or the date of report, whichever is later.

b. Adding a person previously ineligible due to a failure to cooperate. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing paternity as described at 441—subrule 75.14(2) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by cooperating in obtaining medical support or establishing paternity.

c. Adding a person previously ineligible due to failure to provide a social security number. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described at rule 441—75.7(249A) is to be granted Medicaid benefits, the person shall be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

d. Adding a person who was voluntarily excluded. In those instances where a person who has been voluntarily excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A) is being added to the eligible group, the person shall be added effective the first of the month after the month in which the household requests that the person no longer be excluded.

76.12(2) Reinstatement after cancellation. Eligibility for medical assistance may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information.

76.12(3) Loss of HAWK-I eligibility. In those instances where a child loses HAWK-I eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.13(249A) Initial enrollment.

76.13(1) Enrollment date. Applicants who have been determined to be eligible shall be enrolled by the department in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the first month for which eligibility has been determined, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations.

(2) Eligibility under the qualified Medicare beneficiary coverage group begins on the first day of the month after the month of decision.

(3) Eligibility for individuals approved for supplemental security income, programs related to supplemental security income, state supplementary assistance, or medical assistance benefits shall be effective on the first day of the month when the individual was resource-eligible as of the first moment of the first day of the month and met all other eligibility criteria at any time during the month.

(4) When a request is made to add a new person to the eligible group, medical assistance shall not be effective before the first of the month in which the request was made.

(5) When a request is made prior to January 1, 2014, to add to the eligible group a person who previously was excluded, in accordance with the provisions of rule 441—75.59(249A), medical assistance for the person shall be effective no earlier than the first day of the month following the month in which the request was made.

b. Care or services prior to enrollment. No payment shall be made for medical care or services received prior to the effective date of enrollment.

76.13(2) Certification for services. The department shall issue a Medical Assistance Eligibility Card, Form 470-1911, to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions:

a. Presumptive eligibility. A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action, Form 470-2580 or 470-2580(S), which will include certification information.

b. Emergency Medicaid for aliens. An individual who is eligible only for limited emergency Medicaid for aliens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action, Form 470-0485 or Form 470-0485(S), which will include certification information.

76.13(3) Retroactive enrollment.

a. Except as provided in paragraph 76.13(3) “e,” medical assistance shall be available for all or any of the three months preceding the month in which an application is filed to a person who was pregnant, an infant (under the age of one), or a resident of a nursing facility licensed under Iowa Code chapter 135C during any of the three months and who:

(1) Has medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if the application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance shall be made available when an application has been made on behalf of a deceased person who was an infant, pregnant, or a resident of a nursing facility licensed under Iowa Code chapter 135C if the conditions in paragraph 76.13(3) “a” are met.

d. Persons enrolled in Medicaid based on receipt of supplemental security income benefits who wish to make application for Medicaid benefits for the three months preceding the month of application shall complete SSI Medicaid Information, Form 470-0364, 470-0364(S), 470-0364(M), or 470-0364(MS).

e. Exceptions to retroactive enrollment. This subrule does not apply to the following persons who are otherwise eligible for retroactive enrollment:

(1) Persons whose citizenship or alien status has not been verified even though they are eligible during a 90-day reasonable opportunity period.

(2) Persons determined eligible only under presumptive Medicaid benefits.

(3) Persons eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Persons eligible only under the home- and community-based waiver services program.

[ARC 1069C, IAB 10/2/13, effective 10/1/13; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3549C, IAB 1/3/18, effective 2/7/18; ARC 4208C, IAB 1/2/19, effective 2/6/19]

441—76.14(249A) Reenrollment. Reviews of all conditions of eligibility will occur for the purposes of determining continued enrollment in Medicaid.

76.14(1) Reenrollment frequency.

a. Eligibility reviews for eligibility prior to January 1, 2014.

(1) Eligibility reviews shall be made as often as circumstances indicate, but in no instance shall the period of time between reviews exceed 12 months.

(2) Eligibility reviews will be conducted using information contained in and verification supplied with the review form specified in 441—subrule 75.52(3).

(3) When the review form is issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the fifth calendar day of the following month.

(4) When the review form is not issued in the department's regular end-of-month mailing, the member shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

b. Eligibility reviews for eligibility effective on or after January 1, 2014.

(1) Eligibility reviews for members whose eligibility is based on the modified adjusted gross income methodology, who are eligible for Medicaid related to reciprocity for a subsidized adoption, who are eligible for Medicaid programs that are solely state-funded, who are Medicaid-eligible based upon the receipt of Medicaid related to foster care at the time they aged out of foster care, and who are eligible based on breast or cervical cancer treatment shall be conducted once every 12 months and no more frequently.

(2) Eligibility reviews for other members shall be made as often as circumstances indicate, but in no instance shall the period of time between eligibility reviews exceed 12 months.

76.14(2) Reenrollment process.

a. Reenrollment process prior to January 1, 2014.

(1) Within ten working days from the date a written request is issued, the member shall supply, insofar as the member is able, additional information needed to establish continued eligibility.

1. The member shall give written permission for the release of information when the member is unable to furnish information needed to reestablish eligibility.

2. Failure to supply the information or verification requested or refusal to request assistance and authorize the department to secure the requested information from other sources shall serve as a basis for cancellation of Medicaid. Signing a general authorization for release of information to the department does not meet this responsibility.

(2) Information for the eligibility review shall be submitted on Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), with the following exceptions:

1. Persons whose eligibility for Medicaid is related to the family medical assistance program shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

2. Persons whose eligibility for Medicaid is related to supplemental security income and who are receiving state supplementary assistance shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

3. Persons whose eligibility for Medicaid is based on foster care, subsidized adoption or subsidized guardianship shall have continued eligibility determined by submission of Foster Care, Adoption and Guardianship Medicaid Review, Form 470-2914 or Form 470-2914(S).

4. Individuals whose eligibility is for the medically needy coverage group shall complete Medicaid Review, Form 470-3118 or 470-3118(S).

(3) For SSI-related Medicaid for adults, the department may request a face-to-face or telephone interview. Failure of the member to attend a scheduled interview shall serve as a basis for cancellation of assistance for adults. Failure of the member to attend an interview shall not serve as a basis for cancellation of assistance for children.

(4) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all questions answered and is signed, dated and accompanied by verification as required in 441—paragraphs 75.57(1)“f” and 75.57(2)“l.”

(5) Reinstatement. When medical assistance has been canceled for failure to return a completed review form, assistance may be reinstated without a new application if the department receives the completed form within 14 calendar days of the effective date of cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the information.

b. Reenrollment process effective on or after January 1, 2014.

(1) Reenrollment shall be based on information contained in the member's electronic case record or other more current information available through electronic data matches. The member will be notified

of the determination of continued eligibility and the basis of the determination on Notice of Action, Form 470-0485 or Form 470-0485(S). If any information contained in Form 470-0485 or Form 470-0485(S) is inaccurate, the member must sign and return the notice with accurate information within 30 days of the date on the notice.

(2) When eligibility cannot be determined based on information in the electronic case record and data matches, the member will be provided with a prepopulated renewal form and will have 30 days from the date of the renewal form to sign and return the form with necessary information.

1. Members whose eligibility is based on the modified adjusted gross income methodology shall complete and return Medicaid/HAWK-I Review, Form 470-5168, 470-5168(S), 470-5168(M), or 470-5168(MS).

2. Members whose eligibility for Medicaid is not based on the modified adjusted gross income methodology shall complete and return Medicaid Review, Form 470-3118, 470-3118(S), 470-3118(M), or 470-3118(MS) when requested to do so by the department. Members whose eligibility has been determined on the basis of age, blindness or disability must sign and return the notice within 30 days of the date on the notice and provide verification of income and resources before a determination of continued eligibility can be made.

(3) Enrollment will end when information or documentation necessary to complete the determination of continued eligibility is not returned within 30 days. The department shall notify the member on Notice of Action, Form 470-0485 or Form 470-0485(S).

(4) Reconsideration period.

1. For all coverage groups, except those specified in numbered paragraph “2” below, the eligibility of an individual who is terminated for failure to submit the applicable review form or necessary information shall be reconsidered in a timely manner and without requiring an application if the individual subsequently submits the review form within 90 days after the effective date of termination. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the next business day to provide the review form. The eligibility effective date shall go back to the first day of the first month of ineligibility only if all other eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility shall not be granted any earlier than the month in which all eligibility criteria are met.

2. For qualified Medicare beneficiaries (QMBs), the home- and community-based services (HCBS) waiver groups, and the program for all-inclusive care for the elderly (PACE), the provisions in numbered paragraph “1” above shall apply except that the form shall be acted upon and treated like an application. The eligibility effective dates shall also follow rule 441—76.13(249A) for these specified groups.

(5) An individual whose eligibility is not based on the modified adjusted gross income methodology must attend a face-to-face or telephone interview if requested to do so by the department.

[ARC 1069C, IAB 10/2/13, effective 10/1/13; ARC 3353C, IAB 10/11/17, effective 10/1/17; ARC 3354C, IAB 10/11/17, effective 10/1/17; ARC 3550C, IAB 1/3/18, effective 2/7/18]

441—76.15(249A) Report of changes. As a condition of enrollment and continued enrollment for medical assistance, applicants and members shall report changes in circumstances as required in this rule.

76.15(1) Report of changes for eligibility prior to January 1, 2014.

a. In coverage groups for which Medicaid eligibility is determined using the family medical assistance program (FMAP) income and resource policies, members shall report changes as follows:

(1) At the annual review or upon the addition of an individual to the eligible group, members shall report any change in the following:

1. Income from all sources, including any change in care expenses.
2. Resources.
3. Members of the household.
4. School attendance.

5. A stepparent's recovery from an incapacity.
6. Mailing or living address.
7. Payment of child support.
8. Receipt of a social security number.
9. Payment for child support, alimony, or dependents as defined in 441—paragraph 75.57(8) "b."
10. Health insurance premiums or coverage.

(2) Applicants and members shall report any change in the following within ten calendar days of the change:

1. Members of the household.
2. Mailing or living address.
3. Sources of income.
4. Health insurance premiums or coverage.

(3) Members described at 441—subrule 75.1(35) shall also report any change in income from any source and any change in care expenses within ten calendar days of the change.

b. In coverage groups for which Medicaid eligibility is determined using income and resource policies related to the supplemental security income (SSI) program, members shall report any change in the following to the department within ten calendar days of the change. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

- (1) Income from all sources.
- (2) Resources.
- (3) Members of the household.
- (4) Recovery from disability.
- (5) Mailing or living address.
- (6) Health insurance premiums or coverage.
- (7) Medicare premiums or coverage.
- (8) Receipt of social security number.

(9) Gross income of the community spouse or of the dependent children, parents or siblings of the institutionalized or community spouse living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)

(10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.

(11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report when health insurance coverage begins, or when their living or mailing address changes, within ten calendar days.

76.15(2) *Report of changes for eligibility on or after January 1, 2014.* A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the modified adjusted gross income methodology, any change in the following must be reported:

- (1) Income from all sources.
- (2) Members of the household.
- (3) School attendance.
- (4) Mailing or living address.
- (5) Receipt of a social security number.
- (6) Health insurance premiums or coverage.
- (7) Alien or citizenship status.

b. In coverage groups for which Medicaid eligibility is not determined using the modified adjusted gross income methodology, any change in the following must be reported. EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

- (1) Income from all sources.
- (2) Resources.
- (3) Members of the household.
- (4) Recovery from disability.
- (5) Mailing or living address.
- (6) Health insurance premiums or coverage.
- (7) Medicare premiums or coverage.
- (8) Receipt of social security number.
- (9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family. (See definitions in rule 441—75.25(249A).)
- (10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation or spenddown.
- (11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care or based on an adoption assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, receipt of a social security number, and termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

- (1) Income from all sources.
- (2) Mailing or living address.
- (3) Receipt of a social security number.
- (4) Health insurance coverage.
- (5) Alien or citizenship status.

76.15(3) Failure to report. When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible shall be considered an overpayment and subject to recovery from the member.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility shall be evaluated and eligibility shall be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrule 76.13(1), action based on a change reported during a month shall be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in 441—subrule 16.3(1).

76.16(2) When a request is made to add a new person to the eligible group, and that person meets the eligibility requirements, assistance shall be effective the first day of the month in which the request was made unless otherwise specified at rule 441—76.12(249A).

76.16(3) When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.17(249A).

[ARC 1069C, IAB 10/2/13, effective 10/1/13; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—76.17(249A) Automatic redetermination of eligibility. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, an automatic redetermination of eligibility for other Medicaid coverage groups shall be made. If the reason for ineligibility under

the initial coverage group pertained to a condition of eligibility which applies to all coverage groups, such as failure to cooperate, no further redetermination shall be required. When the redetermination is completed, the member shall be notified of the decision in writing. The redetermination process shall be completed as follows:

76.17(1) Information received by the tenth of the month. If information that creates ineligibility under the current coverage group is received in the department by the tenth of the month, the redetermination process shall be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the month following the month in which the information is received.

76.17(2) Information received after the tenth of the month. If information that creates ineligibility under the current coverage group is received in the department after the tenth of the month, the redetermination process shall be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group shall be the first day of the second month following the month in which the information is received.

76.17(3) Change in federal law. If a change in federal law affects the eligibility of large numbers of Medicaid members and the Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR § 435.1003 as amended to January 13, 1997, the redetermination process shall be completed within the extended time limit and the effective date of cancellation for the current coverage group shall be no later than the first day of the month following the month in which the extended time limit expires.

[ARC 1069C, IAB 10/2/13, effective 10/1/13]

These rules are intended to implement Iowa Code sections 249.3, 249.4, 249A.3, and 249A.4.

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CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE
[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

For purposes of this chapter, "managed care organization" means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

79.1(1) Types of reimbursement.

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

- (1) The actual charge made by the provider of service.
- (2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's website at: dhs.iowa.gov/ime/providers/csrp/fee-schedule.

d. Fee for service with cost settlement. Rescinded IAB 10/10/18, effective 12/1/18.

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment pursuant to subparagraph 79.1(1) "e"(3).

(1) The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs.

(2) The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation.

(3) The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 4.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) "aa" and 79.1(16) "h."

h. Indian health facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/14 plus 10%. Air ambulance: Fee schedule in effect 6/30/14 plus 10%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/13 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	Fee schedule in effect 7/1/19. Maximum of 5 days per week.
Audiologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Behavioral health intervention	Fee schedule	Fee schedule in effect 7/1/13.
Behavioral health services	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Birth centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: \$21.11 per 15-minute unit.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Crisis response services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization community-based services	Fee schedule	Fee schedule in effect 2/1/18, not to exceed the daily per diem for crisis stabilization services.
Crisis stabilization residential services	Fee schedule	Fee schedule in effect 2/1/18.
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	<ol style="list-style-type: none"> 1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or \$1.47 per 15-minute unit, \$23.47 per half day, \$46.72 per full day, or \$70.06 per extended day if no Veterans Administration contract.
	For intellectual disability waiver: Fee schedule for the member’s acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17, for intellectual disability waiver: The provider’s rate in effect 6/30/16 plus 1%, converted to a 15-minute or half-day rate. If no 6/30/16 rate, \$1.96 per 15-minute unit or \$31.27 per half day. For daily services, the fee schedule rate published on the department’s website, pursuant to 79.1(1)“c,” for the member’s acuity tier, determined pursuant to 79.1(30).
2. Emergency response system: Personal response system	Fee schedule	Effective 7/1/13, provider’s rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Portable locator system	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: One equipment purchase: \$323.26. Initial one-time fee: \$52.04. Ongoing monthly fee: \$40.47.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$5.20 per 15-minute unit.
5. Nursing care	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$87.99 per visit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.96 per 15-minute unit, not to exceed \$315.09 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$4.78 per 15-minute unit, not to exceed \$315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed \$315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed rate for regular adult day care services.
Intermediate care facility for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with an intellectual disability	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit, not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%, converted to a 15-minute rate. If no 6/30/13 rate: \$4.05 per 15-minute unit.
8. Home-delivered meals	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$8.10 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver effective 7/1/13: \$1,061.11 lifetime maximum. For intellectual disability waiver effective 7/1/13: \$5,305.53 lifetime maximum. For brain injury, health and disability, and physical disability waivers effective 7/1/13: \$6,366.64 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1,440 units per year.
11. Transportation	Fee schedule	Effective 10/1/13: The provider's nonemergency medical transportation contract rate or, in the absence of a nonemergency medical transportation contract rate, the median nonemergency medical transportation contract rate paid per mile or per trip within the member's DHS region.
12. Nutritional counseling	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$8.76 per 15-minute unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/13: \$115.62 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
14. Senior companion	Fee schedule	Effective 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$5.35 per 15-minute unit, not to exceed \$123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, \$3.58 per 15-minute unit, not to exceed \$83.36 per day. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department.
16. Counseling:		
Individual	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit. Rate is divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.
17. Case management	Fee schedule	For brain injury and elderly waivers: Fee schedule in effect 7/1/18.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
18. Supported community living	For brain injury waiver: Retrospectively limited prospective rates. See 79.1(15)	For brain injury waiver effective 7/1/16: \$9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
	For intellectual disability waiver: Fee schedule for the member's acuity tier, determined pursuant to 79.1(30). Retrospectively limited prospective rate for SCL 15-minute unit. See 79.1(15)	For intellectual disability waiver effective 7/1/17: \$9.28 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,059.29 per month.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: The fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
26. Day habilitation	Fee schedule for the member's acuity tier, determined pursuant to 79.1(30)	Effective 7/1/17: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$3.51 per 15-minute unit. For daily service, the fee schedule rate published on the department's website, pursuant to 79.1(1) "c," for the member's acuity tier, determined pursuant to 79.1(30).
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	Effective 7/1/13, \$6,366.64 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: \$24.85 per 15-minute unit.
30. Financial management services	Fee schedule	Effective 7/1/13, provider's rate in effect 6/30/13 plus 3%. If no 6/30/13 rate: \$68.97 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: \$16.07 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget. When an individual who serves as a member's legal representative provides services to the member as allowed by 79.9(7) "b," the payment rate must be based on 441—subparagraph 78.34(13) "g"(2).
35. Assisted living on-call service providers (elderly waiver only)	Fee agreed upon by member and provider	\$26.08 per day.
Health home services provider	Fee schedule based on the member's qualifying health condition(s).	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule. See 79.1(24) "d"	Fee schedule in effect 7/1/18.
2. Home-based habilitation	See 79.1(24) "d"	Effective 7/1/13: \$11.68 per 15-minute unit, not to exceed \$6,083 per month, or \$200 per day.
3. Day habilitation	See 79.1(24) "d"	Effective 7/1/13: \$3.30 per 15-minute unit or \$64.29 per day.
4. Prevocational habilitation Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment: Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed \$3,029.00 per month.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, and medical social services; home health care for maternity patients and children	Fee schedule. See 79.1(26). For members living in a nursing facility, see 441—paragraph 81.6(11)“r.”	Effective 7/1/18: Medicare LUPA rates in effect on 6/30/18 plus a 3% increase.
2. Private-duty nursing and personal cares for members aged 20 or under	Retrospective cost-related. See 79.1(27)	Effective 7/1/13: Actual and allowable cost not to exceed a maximum of 133% of statewide average.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)“d”)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)“g” and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/13 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)“c”	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 6/30/13 plus 1%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)“h” 2. Fee schedule for service provided for all other Medicaid members.	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare). 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for persons with an intellectual disability	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/13 plus 1%.
Nursing facilities:		
1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“1” and (2)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(1)“2” and (2)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(1) and (2) is 110% of the patient-day-weighted median.
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“1” is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16) “d”(3)“2” is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the	See subrules 441—81.6(4) and 81.6(14) and paragraph 81.6(16) “f.” The direct care rate component limit under 441—81.6(16) “f”(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) “f”(3) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
Occupational therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/13 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 6/30/13 plus 1%.
Physical therapists	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Fee schedule in effect 6/30/13 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)“a”	Fee schedule in effect 6/30/13 plus 1%.
Anesthesia services	Fee schedule. See 79.1(7)“d”	Fee schedule in effect 7/1/17. See 79.1(7)“d.”
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Qualified primary care services	See 79.1(7)“c”	Rate provided by 79.1(7)“c”
Podiatrists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Prescribed drugs	See 79.1(8)	Amount pursuant to 79.1(8).
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Fee schedule	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Public health agencies	Fee schedule	Fee schedule rate in effect 6/30/13 plus 1%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Rehabilitation agencies	Fee schedule. For members residing in a nursing facility, see 441—paragraph 81.6(11)“r.”	Medicaid fee schedule in effect 6/30/13 plus 1%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Screening centers	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Speech-language pathologists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
State-operated institutions	Retrospective cost-related	
Subacute mental health facility	Fee schedule	Fee schedule in effect 2/1/18.
Targeted case management providers	Fee schedule	Fee schedule in effect 7/1/18.

79.1(3) Ambulatory surgical centers.

a. Payment is made for facility services on a fee schedule determined by the department and published on the department’s website. These fees are grouped into nine categories corresponding to the difficulty or complexity of the surgical procedure involved.

b. Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)“c”). This payment is made directly to the physician or dentist.

79.1(4) Durable medical equipment, prosthetic devices, medical supply dealers. Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality. Reimbursement over an established Medicaid fee schedule amount may be allowed pursuant to the criteria at 441—paragraph 78.10(5)“n.”

79.1(5) Reimbursement for hospitals.

a. Definitions.

“*Adolescent*” shall mean a Medicaid patient 17 years or younger.

“*Adult*” shall mean a Medicaid patient 18 years or older.

“*Average daily rate*” shall mean the hospital’s final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

“*Base year cost report*” means the hospital’s cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008, except as noted in 79.1(5) “x.” Cost reports shall be reviewed using Medicare’s cost reporting and cost reimbursement principles for those cost reporting periods.

“*Blended base amount*” shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Blended capital costs*” shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Capital costs*” shall mean an add-on to the blended base amount, which shall compensate for Medicaid’s portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital’s base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix adjusted*” shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Case-mix index*” shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

“*Children’s hospitals*” shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children’s hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and

2. Is a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5) "f," so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) "y"(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's

reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)“f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Medicaid inpatient utilization rate” shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children’s hospitals, including hospitals qualifying for disproportionate share as a children’s hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children’s hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Neonatal intensive care unit” shall mean a designated level II or level III neonatal unit.

“Net discharges” shall mean total discharges minus transfers and short stay outliers.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“Rate table listing” shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

“Rebasing” shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

“Rebasing implementation year” means 2008 and every three years thereafter.

“Recalibration” shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

“Short stay day outlier” shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*“f.”*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*“r.”* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*“r.”* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$75,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays. The readmission policy does not apply to the following:

1. Scheduled readmissions that are part of repetitive or periodic treatments; and
2. Critical access hospitals.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5) "r," and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5) "r," which are paid per diem, as specified in paragraph 79.1(5) "i."

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5) "r" and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5) "r" is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5) "a." No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5) "j."

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5) "y" (3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph 79.1(5) "y," for dates of service prior to October 1, 2014. Out-of-state hospitals do not qualify for disproportionate share payments for dates of service on or after October 1, 2014.

(3) Out-of-state hospitals do not qualify for direct medical education or indirect medical education payments pursuant to paragraph 79.1(5) "y."

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph "f."

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)“b”(1), a neonatal intensive care unit under subparagraph 79.1(5)“b”(2), a psychiatric unit under paragraph 79.1(5)“i,” or a physical rehabilitation hospital or unit under paragraph 79.1(5)“i” shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if the unit’s program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)“b”(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)“b”(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit’s certification as a level II or level III neonatal unit in accordance with recommendations

set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5) “i” if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5) “i” if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid DRG blended base amount as otherwise calculated pursuant to this subrule for all “participating hospitals” as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare inpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare inpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be applied until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

t. Limitations and application of limitations on payment. Diagnosis-related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider’s customary charges to the general public for the services. This limit is applied in the aggregate during the cost settlement process at the end of the hospital’s fiscal year.

(2) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. This limit is applied to aggregate Medicaid payments at the end of the state’s fiscal year.

u. State-owned teaching hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) “y,” payment shall be made to Iowa hospitals qualifying for the Iowa state-owned teaching hospital disproportionate share fund. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for Iowa state-owned teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

(2) Allocation to fund. The total amount of funding that is allocated on July 1 of each year to the Iowa state-owned teaching hospital disproportionate share fund is \$26,633,430.

(3) Amount of payment. The total amount of disproportionate share payments from the graduate medical education and disproportionate share fund and from the Iowa state-owned teaching hospital disproportionate share fund shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report.

v. *Non-state-owned teaching hospital disproportionate share payment.* In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5) "y," payment shall be made to Iowa hospitals qualifying for Iowa non-state-government-owned acute care teaching hospital disproportionate share payments. Interim monthly payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph.

(1) Qualifying criteria. A hospital qualifies for the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments if it qualifies for disproportionate share payments pursuant to paragraph 79.1(5) "y" and is an Iowa non-state-government-owned acute care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of disproportionate share payments pursuant to paragraph 79.1(5) "y" and the Iowa non-state-government-owned acute care teaching hospital disproportionate share payments shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(3) Final disproportionate share adjustment. The department's total year-end disproportionate share obligations to a qualifying hospital will be calculated following completion of the desk review or audit of CMS 2552-96, Hospital and Healthcare Complex Cost Report. The department's total year-end disproportionate share obligation shall not exceed the difference between the following:

1. The annual amount appropriated to the IowaCare account for distribution to publicly owned acute care teaching hospitals located in a county with a population over 350,000; and

2. The actual IowaCare expansion population claims submitted and paid by the Iowa Medicaid enterprise to qualifying hospitals.

w. *Rate adjustments for hospital mergers.* When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

- (1) Advertising.
- (2) Promotional items.
- (3) Feasibility studies.
- (4) Administrative travel and entertainment.

- (5) Dues, subscriptions, or membership costs.
- (6) Contributions made to other organizations.
- (7) Home office costs.
- (8) Public relations items.
- (9) Any patient convenience items.
- (10) Management fees for administrative services.
- (11) Luxury employee benefits (i.e., country club dues).
- (12) Motor vehicles for other than patient care.
- (13) Reorganization costs.

y. *Graduate medical education and disproportionate share fund.* Payment shall be made to hospitals in Iowa qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services is \$7,594,294.03. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

(4) Qualifying for indirect medical education. Iowa hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size. Out-of-state hospitals do not qualify for indirect medical education payments.

(5) Allocation to fund for indirect medical education. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services is \$13,450,285.14. If a hospital fails to qualify for indirect medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10). Information contained in the hospital's base year cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

1. For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

2. For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

3. For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

4. For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

5. Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

6. Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

7. Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

8. Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total state fiscal year annual amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments is \$6,959,868.59. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from the GME/DSH fund apportionment claim set for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the GME/DSH fund and supplemental disproportionate share of payments pursuant to paragraph 79.1(5) "u" or 79.1(5) "v" cannot exceed the amount of the federal cap under Public Law 102-234.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age. In addition, the hospital must be a voting member of the National Association of Children's Hospitals and Related Institutions for dates of service prior to October 1, 2014, or a member of the National Association of Children's Hospitals and Related Institutions for dates of service on or after October 1, 2014.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audit and rate setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)"a" to "z" are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to paragraphs 79.1(5)"a" to "z." Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)"k."

ab. Nonpayment for preventable conditions. Preventable conditions identified pursuant to this rule that develop during inpatient hospital treatment shall not be considered in determining reimbursement for such treatment.

(1) Coding. All diagnoses included on an inpatient hospital claim must include one of the following codes indicating whether the condition was present or developing at the time of the order for inpatient admission:

Present on Admission (POA) Indicator Codes

Code Explanation

Y	The condition was present or developing at the time of the order for inpatient admission.
N	The condition was not present or developing at the time of the order for inpatient admission.
U	Documentation is insufficient to determine whether the condition was present or developing at the time of the order for inpatient admission.
W	Clinically undetermined. The provider is clinically unable to determine whether or not the condition was present or developing at the time of the order for inpatient admission.

(2) Payment processing. Claims will be processed according to the DRG methodology without consideration of any diagnosis identified by the Secretary of the United States Department of Health and Human Services pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)) if the condition was not present or developing at the time of the order for inpatient admission.

ac. Rural hospital disproportionate share payment. In addition to payments from the graduate medical education and disproportionate share fund made pursuant to paragraph 79.1(5)"j," payment shall be made to qualifying Iowa hospitals that elect to participate in rural hospital disproportionate share payments. Interim monthly payments will be made based on the amount of state share that is transferred to the department.

(1) **Qualifying criteria.** A hospital that qualifies for disproportionate share payments pursuant to paragraph 79.1(5)“y” and that is a rural prospective payment hospital not designated as a critical access hospital qualifies for rural hospital disproportionate share payments.

(2) **Source of nonfederal share.** The required nonfederal share shall be funds generated from tax levy collections of the county or city in which the hospital is located, and is subject to the conditions specified in this subparagraph and applicable federal law and regulations.

1. The nonfederal share funds shall be distributed to the department prior to the issuance of any disproportionate share payment to a qualifying hospital.

2. The city or county providing the nonfederal share funds shall annually document and certify that the funds provided as the nonfederal share were generated from tax proceeds, and not from any other source including federal grants or another federal funding source.

3. The applicable federal matching rate for the fiscal year shall apply.

(3) **Amount of payment.** The total amount of disproportionate share payments made pursuant to paragraph 79.1(5)“y” and the rural hospital disproportionate share payments shall not exceed the amount of the state’s allotment under Public Law 102-234. In addition, the total amount of all disproportionate share payments shall not exceed the hospital-specific disproportionate share limits under Public Law 103-666.

(4) **Final disproportionate share adjustment.** Qualifying hospitals shall annually provide a disproportionate share hospital survey within the time frames specified by the department, for the purpose of calculating the hospital-specific disproportionate share limits under Public Law 103-666.

79.1(6) Independent laboratories. The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician’s Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) Physicians.

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician’s Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)“e” for the guidelines for immunization replacement.

b. Payment reduction for services rendered in facility settings. The fee schedule amount paid to physicians based on paragraph 79.1(7)“a” shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician’s office. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following (consistent with “POS” definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

- (1) Telehealth (POS 02).
- (2) Outpatient hospital-off campus (POS 19).
- (3) Inpatient hospital (POS 21).
- (4) Outpatient hospital-on campus (POS 22).
- (5) Emergency room-hospital (POS 23).
- (6) Ambulatory surgical center (POS 24).
- (7) Military treatment center (POS 26).
- (8) Skilled nursing facility (POS 31).
- (9) Hospice-for inpatient care (POS 34).
- (10) Ambulance-land (POS 41).
- (11) Ambulance-air or water (POS 42).
- (12) Inpatient psychiatric facility (POS 51).
- (13) Psychiatric facility-partial hospitalization (POS 52).
- (14) Community mental health center (POS 53).
- (15) Psychiatric residential treatment center (POS 56).

(16) Comprehensive inpatient rehabilitation (POS 61).

c. Payment for primary care services. To the extent required by 42 U.S.C. § 1396a(a)(13)(C), primary care services furnished in calendar year 2013 or 2014 by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (4) and (6) of this paragraph (79.1(7)“c”). Primary care services furnished January 1, 2015, through June 30, 2017, by a qualified primary care physician or under the supervision of a qualified primary care physician shall be paid as provided pursuant to subparagraphs (1) to (3), (5), and (7) of this paragraph (79.1(7)“c”).

(1) Primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) include:

1. Evaluation and management (E & M) services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 99201 through 99499, or their successor codes; and

2. Vaccine administration services covered by Iowa Medicaid and designated in the healthcare common procedure coding system (HCPCS) as codes 90460, 90461, 90471, 90472, 90473 and 90474, or their successor codes.

(2) For purposes of this paragraph (79.1(7)“c”), a qualified primary care physician is a physician who:

1. Is certified by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA) with a specialty designation of family medicine, general internal medicine, or pediatric medicine or with a subspecialty designation recognized by the certifying organization as a subspecialty of family medicine, general internal medicine, or pediatric medicine; or

2. Has furnished primary care services eligible for payment pursuant to this paragraph (79.1(7)“c”) equal to at least 60 percent of the Iowa Medicaid services for which the qualified primary care physician has submitted claims during the most recently completed calendar year or, for newly eligible physicians, the prior month (excluding claims not paid and claims for which Medicare is the primary payer).

(3) For payment to be made under this paragraph (79.1(7)“c”), the qualified primary care physician must have certified that the physician is a qualified primary care physician by submitting Form 470-5138, Iowa Medicaid Primary Care Physician Certification and Attestation for Primary Care Rate Increase, prior to the date of service or by April 1, 2013, for services rendered January 1, 2013, through April 1, 2013.

(4) Primary care services rendered in calendar year 2013 or 2014. Primary care services rendered in calendar year 2013 or 2014 that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B, in effect for services rendered on the first day of the calendar year;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on the first day of the calendar year, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1).

(5) Primary care services rendered on or after January 1, 2015. Primary care services rendered on or after January 1, 2015, that are eligible for payment pursuant to this rule shall be paid at the greater of:

1. The otherwise applicable Iowa Medicaid rate;

2. The applicable rate under Medicare Part B in effect for services rendered on January 1, 2014;

3. The rate that would be applicable under Medicare Part B, in effect for services rendered on January 1, 2014, if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009; or

4. If there is no applicable rate under Medicare Part B, the rate specified in a fee schedule established and announced by the federal Centers for Medicare and Medicaid Services, pursuant to 42 CFR § 447.405(a)(1), and in effect on June 30, 2014.

(6) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program in calendar year 2013 or 2014 shall be limited to the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program; or

2. The applicable Medicare fee schedule rate for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

(7) Notwithstanding the foregoing provisions of this paragraph (79.1(7)“c”), payment for the administration of vaccines provided under the Vaccines for Children Program on or after January 1, 2015, shall be the lesser of:

1. The regional maximum administration fee under the Vaccines for Children Program in effect on June 30, 2014; or

2. The applicable Medicare fee schedule rate in effect on June 30, 2014, for HCPCS code 90460 (or, if higher, the Medicare fee schedule rate for HCPCS code 90460 rate that would apply if the conversion factor under 42 U.S.C. § 1395w-4(d) were the conversion factor for 2009).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)“c.” Anesthesia procedures listed in the fee schedule with a factor code of “F” are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of “A” are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is \$1.40, which will be updated annually on January 1.

79.1(8) Drugs.

a. Except as provided below in paragraphs 79.1(8)“d” through “i,” all providers are reimbursed for covered drugs as follows:

(1) Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

3. The total submitted charge, represented by the lower of the gross amount due (GAD) as defined by the National Council for Prescription Drug Programs (NCPDP) standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee, determined pursuant to paragraph 79.1(8)“c”; or

4. Providers’ usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)“b,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“c”;

2. The total submitted charge, represented by the lower of the GAD as defined by the NCPDP standards definition, or the ingredient cost submitted plus the state defined professional dispensing fee;

or

3. Providers’ usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department's discretion. The average state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise website. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. Professional dispensing fee.

(1) For purposes of this subrule, the professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers' costs of dispensing drugs to Medicaid beneficiaries. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

(2) There is a one-time professional dispensing fee reimbursed per one-month or three-month period, accounting for the refill tolerance of 90 percent consumption, per member, per drug, per strength, billed per provider for maintenance drugs as identified by MediSpan and maintenance nonprescription drugs.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL. Payment may be made only for unit-dose-packaged drugs that are consumed by the patient. Any previous charges for unused unit-dose packages returned to the pharmacy must be credited to the Medicaid program, consistent with the Iowa board of pharmacy's rules on return of drugs.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8) "a" above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

2. The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

4. The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8) "a" because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8) "a" above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the FSS price), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(2) The average state AAC determined pursuant to paragraph 79.1(8) "b" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8) "a"(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8) "c";

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)“a” above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug’s “best price” pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider’s actual acquisition cost (not to exceed the nominal price paid), submitted in the ingredient cost field, plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(2) The average state AAC determined pursuant to paragraph 79.1(8)“b” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)“a”(1)“2” plus the professional dispensing fee pursuant to paragraph 79.1(8)“c”;

(4) The total submitted charge, represented by the GAD as defined by the NCPDP standards definition; or

(5) Providers’ usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)“a” through “f.” The pharmacy encounter rate is the current “outpatient per visit rate (excluding Medicare)” approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Vaccines for Children Program. All providers administering vaccines available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

j. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)“a” through “f,” payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to the physician payment policy under subrule 79.1(2).

k. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

79.1(9) *HCBS consumer choices financial management.* Rescinded IAB 5/8/19, effective 7/1/19.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person’s services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent’s compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under Part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the Part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment of \$1 for each covered prescription or refill of any covered drug.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

- i.* Copayment charges are not applicable to services furnished pregnant women.
- j.* All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.
- k.* Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:
 - (1) Placing the patient's health in serious jeopardy,
 - (2) Serious impairment to bodily functions, or
 - (3) Serious dysfunction of any bodily organ or part.
- l.* Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.
- m.* No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.
- n.* The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect

the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) HCBS retrospectively limited prospective rates. This methodology applies to reimbursement for HCBS brain injury waiver supported community living; HCBS intellectual disability waiver supported community living for 15-minute services; HCBS family and community support services; and HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency.

a. *Reporting requirements.*

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) 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 noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed \$1,570 per consumer per year for supported community living services in the brain injury waiver.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed \$1,500 per child per year for family and community support services.

(9) The reasonable costs of direct care staff training shall be treated as direct care costs, rather than as indirect administrative costs.

c. Prospective rates for new providers.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph "e."

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph "d."

d. Prospective rates for established providers.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph "f."

e. Prospective rates for respite. Rescinded IAB 5/1/13, effective 7/1/13.

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) For services provided from July 1, 2015, through June 30, 2016, revenues exceeding adjusted actual costs by more than 4.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) For services provided from July 1, 2015, through June 30, 2016, providers who do not reimburse revenues exceeding 104.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 104.5 percent of the actual costs deducted from future payments.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or "APC" means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or "APC relative weight" means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

“*Cost outlier*” shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph “g” and are therefore eligible for additional payments above and beyond the base APC payment.

“*Current procedural terminology—fourth edition (CPT-4)*” is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

“*Diagnostic service*” means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

“*Direct medical education costs*” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

“*Direct medical education rate*” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“*Discount factor*” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“*GME/DSH fund apportionment claim set*” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“*GME/DSH fund implementation year*” means 2009.

“*Graduate medical education and disproportionate share fund*” or “*GME/DSH fund*” means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“*Healthcare common procedures coding system*” or “*HCPCS*” means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“*Hospital-based clinic*” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“*Medicaid claim set*” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“*Modifier*” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“*Multiple significant procedure discounting*” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“*Observation services*” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“*Outpatient hospital services*” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“*Outpatient prospective payment system*” or “*OPPS*” means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“*Outpatient visit*” shall mean those hospital-based outpatient services which are billed on a single claim form.

“*Packaged service*” means a service that is secondary to other services but is considered an integral part of another service.

“*Pass-through*” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“*Quality improvement organization*” or “*QIO*” shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPSS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPSS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: <ul style="list-style-type: none"> ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.” If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” ● In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> ● Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” ● In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.
2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.
3. The total calculated Medicaid cost for ambulance services for all hospitals.
4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

- (1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room.

1. For members who were referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,766,718.25. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus

2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus

3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification and equipment.* Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Coinsurance*” means a percentage of costs of a covered health care service that has to be paid.

“*Copayment*” means a fixed amount a member pays for a covered health care service.

“*Deductible*” means the amount paid for covered health care services before the insurance plan will effect payment.

“*Medicaid-allowed amount*” means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicare-allowed amount*” means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare cost sharing*” means the Medicare member's responsibility to pay for a Medicare-covered service. “Medicare cost sharing” includes coinsurance, copayments, and deductibles.

“*Medicare crossover claim*” means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare 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.

“*Medicare deductible and coinsurance amounts*” means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Medicare provider reimbursement*” means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

“*Qualified Medicare beneficiary*” or “*QMB*” means an individual who has been determined eligible for the QMB program pursuant to 441—subrule 75.1(29). Under the QMB program, Medicaid pays the individual’s Medicare Part A and B premiums; coinsurance; copayment; and deductible (except for Part D).

“*Third-party payment*” means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. Reimbursement of Medicare crossover claims. Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services provided before July 1, 2011, shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1). The unit of service may be a quarter hour, a half hour, an hour, a half day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year’s retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider’s fiscal year that are consistent with Medicaid’s obligation to reimburse that provider’s reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)“c”(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider’s financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider’s Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider’s fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings, less 5 percent.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) Reimbursement for home- and community-based habilitation services. Reimbursement for all home- and community-based habilitation services provided on or after January 1, 2016, shall be as provided in paragraph 79.1(24) "d." All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is 15 minutes.

(2) A unit of home-based habilitation is a 15-minute unit (for up to 31 units per day) or one day (for 8 or more hours per day), based on the average hours of service provided during a 24-hour period as an average over a calendar month. Reimbursement for services shall not exceed the upper limit for daily home-based habilitation services set in 79.1(2).

1. The daily unit of service shall be used when a member receives services for 8 or more hours provided during a 24-hour period as an average over a calendar month. The 15-minute unit shall be used when the member receives services for 1 to 31 15-minute units provided during a 24-hour period as an average over a calendar month.

2. The member's comprehensive service plan must identify and reflect the need for the amount of supervision and skills training requested. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

(3) A unit of day habilitation is 15 minutes (up to 16 units per day) or a full day (4.25 to 8 hours).

(4) A unit of supported employment habilitation supports to maintain employment is a 15-minute unit.

b. Submission of cost reports. For services provided prior to July 1, 2013, the department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed \$1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report for services provided through June 30, 2013, that meets the requirements of this paragraph, the Iowa Medicaid enterprise or the Iowa Plan for Behavioral Health contractor shall reduce the provider's rate to 76 percent of the current rate. The reduced rate shall be paid until the provider's cost report has been received by the Iowa Medicaid enterprise's provider cost audit and rate setting unit pursuant to subparagraph 79.1(24) "b"(4) but for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. For services provided prior to July 1, 2013, reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

d. Reimbursement for services provided on or after January 1, 2016.

(1) For dates of services on or after January 1, 2016, habilitation services, except for case management, shall be reimbursed by fee schedule. Case management will continue to be reimbursed by retrospective cost settlement.

(2) For dates of services on or after July 1, 2018, case management services shall be reimbursed by fee schedule.

79.1(25) Reimbursement for community mental health centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).

a. Reimbursement methodology for providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3). Effective for services rendered on or after October 1, 2006, providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles.

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100 percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

c. Cost-based reimbursement. For providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) and CMHCs that elect the 100 percent of reasonable costs basis of reimbursement, rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report, pursuant to the following.

(1) Until a provider that was enrolled in the Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

d. Reporting requirements. All providers other than CMHCs that have elected the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services shall submit cost reports using Form 470-4419, Financial and Statistical Report. Hospital-based providers required to submit a cost report shall also submit the Medicare cost report, CMS Form 2552-96. The following requirements apply to all required cost reports.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

79.1(26) Home health services.

a. Services included under the home health services program are reimbursed on the low utilization payment amount (LUPA) methodology, with state geographic adjustments.

b. Medicare LUPA per-visit rates in effect on July 1, 2013, are the basis for establishing the LUPA methodology for the initial reimbursement schedule.

c. Medicare LUPA per-visit rates shall be increased July 1 every two years to reflect the most recent Medicare LUPA rates.

d. Home health services subject to this methodology are skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services provided by Medicare-certified home health agencies.

79.1(27) Reimbursement for early periodic screening, diagnosis, and treatment private duty nursing and personal cares program.

a. *Rate determination based on cost reports.* Reimbursement shall be made using an hourly rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation not to exceed the upper limit as provided in subrule 79.1(2).

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated 15-minute and hourly rate. Pending determination of private duty nursing and personal cares program costs, the provider may bill for and shall be reimbursed at an hourly rate that the provider and the Iowa Medicaid enterprise (IME) may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review or audit or both by the Iowa Medicaid enterprise to determine the actual cost of services in accordance with generally accepted accounting principles, Medicare cost principles published in Centers for Medicare and Medicaid Services Publication §15-1, and the Office of Management and Budget Circular A-87, Attachment B, subject to the exceptions and limitations in the department's administrative rules.

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount that the provider received during the year for covered services through interim rates and the reasonable and proper costs of operation determined in accordance with this subrule.

b. *Financial and statistical report submission and reporting requirements.*

(1) The provider shall submit the complete Financial and Statistical Report, Form 1728-94, in an electronic format approved by the department to the IME provider cost audit and rate setting unit within five months of the end of the provider's fiscal year.

(2) The submission of the financial and statistical report must include a working trial balance that corresponds to the data contained on the financial and statistical report and the Medicare cost report. Financial and statistical reports submitted without a working trial balance and the Medicare cost report will be considered incomplete.

(3) A provider may obtain a 30-day extension for submitting the financial and statistical report by sending a letter to the IME provider cost audit and rate setting unit. The extension request must be received by the IME provider cost audit and rate setting unit before the original due date. No extensions will be granted beyond 30 days.

(4) Providers shall submit a completed financial and statistical report to the IME provider cost audit and rate setting unit in an electronic format that can be opened using the extension xls or xlsx. The supplemental documentation shall be submitted in a generally accepted business format. The report and required supplemental information shall be emailed to costaudit@dhs.state.ia.us on or before the last day of the fifth month after the end of the provider's fiscal year. One signed copy of the certification page of the Medicaid and Medicare cost reports shall be mailed to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, no later than the due date of the required electronic submissions.

(5) If a provider fails to submit a cost report that meets the requirement of subparagraph 79.1(27) "b"(4), the department shall reduce payment to 75 percent of the current rate(s).

1. The reduced rate(s) 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 IME provider cost audit and rate setting unit.

2. The reduced rate(s) 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 IME provider cost audit and rate setting unit.

(6) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting and provide documentation detailing these adjustments. Failure to maintain records to support the cost report may result in the following, but not limited to:

1. Recoupment of Medicaid payments.
2. Penalties.
3. Sanctions pursuant to rule 441—79.3(249A).

(7) The department, in its sole discretion, may on its own initiative 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 to submit an amended financial and statistical report for review by the department, after the provider is notified of its reimbursement rates following review of a financial and statistical report.

(8) A projected cost report shall be submitted when a home health agency enters the program or adds private duty nursing and the personal cares program. Prospective interim rates shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new program is added.

(9) A provider of services under multiple programs shall submit a cost allocation schedule that was used during the preparation of the financial and statistical report.

(10) Costs reported under private duty nursing and the personal cares program shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under private duty nursing and the personal cares program.

(11) When a provider continues to include as an item of cost an item or items which had in a prior period been removed by an adjustment by the department or its contractor, in the total program costs, the contractor shall recommend to the department that the reimbursement rates be reduced to 75 percent of the current reimbursement rate for the entire quarter beginning the first day of the sixth month after the provider's fiscal year end. The department may, after considering the seriousness of the exception, make the reduction.

(12) Nothing in this subrule relieves a provider of its obligation to immediately inform the department that it has retained Medicaid funds to which it is not entitled as a result of any cost report process. A provider must notify the Iowa Medicaid enterprise when the provider notes that funds are incorrectly paid or when an overpayment has been detected.

c. Terminated home health agencies.

(1) A participating home health agency contemplating termination of private duty nursing and the personal cares program shall provide the department of human services with at least 60 days' prior notice. The person responsible for the termination is responsible for submission of a final financial and statistical report through the date of the termination. The final home health cost report shall meet the reporting requirements in paragraph 79.1(27) "b."

(2) For facilities that terminate activity with the Iowa Medicaid enterprise, a financial and statistical report from the beginning of the fiscal year to the date of termination will be required, regardless if termination is voluntary, involuntary or due to a change in ownership. All documentation in paragraph 79.1(27) "a" shall be submitted 45 days after the date of termination, by the terminated (closed) entity. If no report is received within 45 days, the Iowa Medicaid enterprise will begin the process to recoup all funds for dates of service beginning from the last filed cost report to the date of termination.

79.1(28) Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

79.1(29) *Reimbursement for health insurance premium payment (HIPP) program providers.* Reimbursement for HIPP program providers shall be provided only when such provider is enrolled with Iowa Medicaid for the sole purpose of billing HIPP-eligible in-network coinsurance, copayments, and deductibles.

a. Definitions. For purposes of this subrule:

"*Coinsurance*" means a percentage of costs of a covered health care service that has to be paid.

"*Copayment*" means a fixed amount a member pays for a covered health care service.

"*Deductible*" means the amount paid for covered health care services before the insurance plan starts to pay.

"*Eligible member*" means an individual eligible for Medicaid pursuant to rule 441—75.1(249A) et seq. and who qualifies for and is participating in the department's HIPP program prescribed under rule 441—75.21(249A).

"*Health insurance premium payment (HIPP) program*" or "*HIPP program*" has the same meaning as provided in rule 441—75.21(249A).

b. Claim submission. To submit a claim for reimbursement, a HIPP provider shall use Form 470-5475, Health Insurance Premium Payment (HIPP) Provider Invoice.

(1) Payment shall be made to eligible providers for a HIPP-eligible member's coinsurance, copayment, and deductible, when the HIPP-eligible member is active on the date of service.

(2) Member responsibility. The eligible member may be responsible for a copayment pursuant to subrule 79.1(13).

79.1(30) *Tiered rates.* For supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the intellectual disability waiver, the fee schedule published by the department pursuant to paragraph 79.1(1) "*c*" provides rates based on the acuity tier of the member, as determined pursuant to this subrule.

a. Acuity tiers are based on the results of the Supports Intensity Scale® (SIS) core standardized assessment. The SIS assessment tool and scoring criteria are available on request from the Iowa Medicaid enterprise, bureau of long-term care.

b. The assignment of members to acuity tiers is based on a mathematically valid process that identifies meaningful differences in the support needs of the members based on the SIS scores.

c. For supported community living daily services paid through a per diem, there are two reimbursement sublevels within each tier based on the number of hours of day services a member receives monthly. Day services include enhanced job search services, supported employment, prevocational services, adult day care, day habilitation and employment outside of Medicaid reimbursable services. The two reimbursement sublevels reflect reimbursement for:

(1) Members who receive an average of 40 hours or more of day services per month.

(2) Members who receive an average of less than 40 hours of day services per month.

d. For this purpose, the "SIS activities score" is the sum total of the subscale raw SIS scores converted to standard scores on the following subsections:

(1) Subsection 2A: Home Living Activities;

(2) Subsection 2B: Community Living Activities;

(3) Subsection 2E: Health and Safety Activities; and

(4) Subsection 2F: Social Activities.

e. Also used in determining a member's acuity tier, as provided in paragraphs 79.1(30) "*f*" and "*g*," are the subtotal scores on the following subsections:

(1) Subsection 1A: Exceptional Medical Support Needs, excluding questions 16 through 19; and

(2) Subsection 1B: Exceptional Behavioral Support Needs, excluding question 13.

f. Subject to adjustment pursuant to paragraph 79.1(30) "*g*," acuity tiers are the highest applicable tier pursuant to the following:

- (1) Tier 1: SIS activities score of 0 – 25.
- (2) Tier 2: SIS activities score of 26 – 40.
- (3) Tier 3: SIS activities score of 41 – 44 or SIS activities score of 0 – 40 and a SIS subsection 1B subtotal score of 6 or higher.
- (4) Tier 4: SIS activities score of 45 or higher.
- (5) Tier 5: SIS activities score of 41 or higher and a subsection 1B subtotal score of 7 or higher.
- (6) Tier 6: SIS subsection 1A or 1B subtotal score of 14 or higher.
- (7) RCF tier: Members residing in a residential care facility (RCF) licensed for six or more beds.
- (8) RBSCCL tier: Members residing in a residential-based supported community living (RBSCCL) facility.
- (9) Enhanced tier: An individual member rate negotiated between the department and the provider.
 - g. The tier determined pursuant to paragraph 79.1(30)“f” shall be adjusted as follows:
 - (1) For members with a subsection 1A subtotal score of 2 or 3, as provided in subparagraph 79.1(30)“e”(1), but with a response of “extensive support needed” (score = 2) in response to any prompt in subsection 1A, as provided in subparagraph 79.1(30)“e”(1) and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (2) For members with a subsection 1A subtotal score of 4 – 9, and an otherwise applicable tier of 1 to 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (3) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 1 to 3 pursuant to paragraph 79.1(30)“f,” the tier is increased by two tiers.
 - (4) For members with a subsection 1A subtotal score of 10 – 13, and an otherwise applicable tier of 4 pursuant to paragraph 79.1(30)“f,” the tier is increased by one tier.
 - (5) Any member may receive an enhanced tier rate when approved by the department for fee-for-service members.
 - h. Tier redetermination. A member’s acuity tier may be changed in the following circumstances:
 - (1) There is a change in the member’s SIS activity scores as determined in the annual level of care redetermination process pursuant to rule 441—83.64(249A).
 - (2) A completed DHS Form 470-5486, Emergency Needs Assessment, indicates a change in the member’s support needs. A member’s case manager may request an emergency needs assessment when a significant change in the member’s needs is identified. When a completed emergency needs assessment indicates significant changes that are likely to continue in three of the five domains assessed, a full SIS core standardized assessment shall be conducted and any change in the SIS scores will be used to determine the member’s acuity tier.
 - i. New providers, provider acquisitions, mergers and change in ownership. Any change in provider enrollment status including, but not limited to, new providers, enrolled providers merging into one or more consolidated provider entities, acquisition or takeover of existing HCBS providers,

or change in the majority ownership of a provider on or after December 1, 2017, shall require the new provider entity to use the tiered rate fee schedule in accordance with paragraph 79.1(1)“c.”

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

[ARC 7835B, IAB 6/3/09, effective 7/8/09; ARC 7937B, IAB 7/1/09, effective 7/1/09; ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 8205B, IAB 10/7/09, effective 11/11/09; ARC 8206B, IAB 10/7/09, effective 11/11/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8647B, IAB 4/7/10, effective 3/11/10; ARC 8649B, IAB 4/7/10, effective 3/11/10; ARC 8894B, IAB 6/30/10, effective 7/1/10; ARC 8899B, IAB 6/30/10, effective 7/1/10; ARC 9046B, IAB 9/8/10, effective 8/12/10; ARC 9127B, IAB 10/6/10, effective 11/10/10; ARC 9134B, IAB 10/6/10, effective 10/1/10; ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9176B, IAB 11/3/10, effective 12/8/10; ARC 9316B, IAB 12/29/10, effective 2/2/11; ARC 9403B, IAB 3/9/11, effective 5/1/11; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 9588B, IAB 6/29/11, effective 9/1/11; ARC 9706B, IAB 9/7/11, effective 8/17/11; ARC 9708B, IAB 9/7/11, effective 8/17/11; ARC 9710B, IAB 9/7/11, effective 8/17/11; ARC 9704B, IAB 9/7/11, effective 9/1/11; ARC 9712B, IAB 9/7/11, effective 9/1/11; ARC 9714B, IAB 9/7/11, effective 9/1/11; ARC 9719B, IAB 9/7/11, effective 9/1/11; ARC 9722B, IAB 9/7/11, effective 9/1/11; ARC 9884B, IAB 11/30/11, effective 1/4/12; ARC 9886B, IAB 11/30/11, effective 1/4/12; ARC 9887B, IAB 11/30/11, effective 1/4/12; ARC 9958B, IAB 1/11/12, effective 2/15/12; ARC 9959B, IAB 1/11/12, effective 2/15/12; ARC 9960B, IAB 1/11/12, effective 2/15/12; ARC 9966B, IAB 2/8/12, effective 1/19/12; ARC 0028C, IAB 3/7/12, effective 4/11/12; ARC 0029C, IAB 3/7/12, effective 4/11/12; ARC 9959B nullified (See nullification note at end of chapter); ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0194C, IAB 7/11/12, effective 7/1/12; ARC 0196C, IAB 7/11/12, effective 7/1/12; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0355C, IAB 10/3/12, effective 12/1/12; ARC 0354C, IAB 10/3/12, effective 12/1/12; ARC 0360C, IAB 10/3/12, effective 12/1/12; ARC 0485C, IAB 12/12/12, effective 2/1/13; ARC 0545C, IAB 1/9/13, effective 3/1/13; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0581C, IAB 2/6/13, effective 4/1/13; ARC 0585C, IAB 2/6/13, effective 1/9/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0708C, IAB 5/1/13, effective 7/1/13; ARC 0710C, IAB 5/1/13, effective 7/1/13; ARC 0713C, IAB 5/1/13, effective 7/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0823C, IAB 7/10/13, effective 9/1/13; ARC 0838C, IAB 7/24/13, effective 7/1/13; ARC 0840C, IAB 7/24/13, effective 7/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 0848C, IAB 7/24/13, effective 7/1/13; ARC 0864C, IAB 7/24/13, effective 7/1/13; ARC 0994C, IAB 9/4/13, effective 11/1/13; ARC 1051C, IAB 10/2/13, effective 11/6/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1057C, IAB 10/2/13, effective 11/6/13; ARC 1058C, IAB 10/2/13, effective 11/6/13; ARC 1071C, IAB 10/2/13, effective 10/1/13; ARC 1150C, IAB 10/30/13, effective 1/1/14; ARC 1152C, IAB 10/30/13, effective 1/1/14; ARC 1154C, IAB 10/30/13, effective 1/1/14; ARC 1481C, IAB 6/11/14, effective 8/1/14; ARC 1519C, IAB 7/9/14, effective 7/1/14; ARC 1521C, IAB 7/9/14, effective 7/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14; ARC 1608C, IAB 9/3/14, effective 10/8/14; ARC 1609C, IAB 9/3/14, effective 10/8/14; ARC 1699C, IAB 10/29/14, effective 1/1/15; ARC 1697C, IAB 10/29/14, effective 1/1/15; ARC 1977C, IAB 4/29/15, effective 7/1/15; ARC 2026C, IAB 6/10/15, effective 8/1/15; ARC 2075C, IAB 8/5/15, effective 7/15/15; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2167C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2846C, IAB 12/7/16, effective 11/15/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2930C, IAB 2/1/17, effective 4/1/17; ARC 2932C, IAB 2/1/17, effective 3/8/17; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3158C, IAB 7/5/17, effective 7/1/17; ARC 3161C, IAB 7/5/17, effective 7/1/17; ARC 3162C, IAB 7/5/17, effective 7/1/17; ARC 3160C, IAB 7/5/17, effective 7/1/17; ARC 3159C, IAB 7/5/17, effective 7/1/17; ARC 3294C, IAB 8/30/17, effective 10/4/17; ARC 3295C, IAB 8/30/17, effective 10/4/17; ARC 3296C, IAB 8/30/17, effective 10/4/17; ARC 3292C, IAB 8/30/17, effective 10/4/17; ARC 3293C, IAB 8/30/17, effective 10/4/17; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3494C, IAB 12/6/17, effective 1/10/18; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 3790C, IAB 5/9/18, effective 6/13/18; ARC 4067C, IAB 10/10/18, effective 11/14/18; ARC 4065C, IAB 10/10/18, effective 12/1/18; ARC 4066C, IAB 10/10/18, effective 12/1/18; ARC 4068C, IAB 10/10/18, effective 12/1/18; ARC 4430C, IAB 5/8/19, effective 7/1/19; see Delay note at end of chapter; ARC 4899C, IAB 2/12/20, effective 3/18/20; ARC 4974C, IAB 3/11/20, effective 4/15/20]

441—79.2(249A) Sanctions.

79.2(1) Definitions.

“*Affiliates*” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

“*Iowa Medicaid enterprise*” means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

“*Person*” means any individual human being or any company, firm, association, corporation, institution, or other legal entity. “*Person*” includes but is not limited to a provider and any affiliate of a provider.

“*Probation*” means a specified period of conditional participation in the medical assistance program.

“*Provider*” means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

“*Suspension from participation*” means an exclusion from participation for a specified period of time.

“*Suspension of payments*” means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

“*Termination from participation*” means a permanent exclusion from participation in the medical assistance program.

“*Withholding of payments*” means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.

79.2(2) Grounds for sanctions. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. Upon lawful demand, failing to disclose or make available to the department, the department’s authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals’ Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.

e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, “quality services” means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department’s representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.

i. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

j. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

l. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.

m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.

n. Exclusion from Medicare or any other state or federally funded medical assistance program.

o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

- p.* Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q.* Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r.* Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.
- s.* Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.
- t.* Violation of a condition of probation, suspension of payments, or other sanction.
- u.* Loss, restriction, or lack of hospital privileges for cause.
- v.* Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w.* Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x.* Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y.* Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) Sanctions.

- a.* The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.
- b.* The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c.* Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.

79.2(4) Imposition and extent of sanction. The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:

- a.* Seriousness of the offense.

- b. Extent of violations.
- c. History of prior violations.
- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.

79.2(6) Notice to third parties. When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) Notice of violation.

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the provider.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8) Suspension or withholding of payments. The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9) Civil monetary penalties and interest. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) Report and return of identified overpayment.

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

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

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request shall result in claim denial or recoupment.

79.3(1) Financial (fiscal) records.

a. A provider of service shall maintain records as necessary to:

- (1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
- (2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

- (1) The provision of each service and each activity billed to the program; and
- (2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

- (1) Medically necessary;
- (2) Consistent with the diagnosis of the member's condition; and
- (3) Consistent with professionally recognized standards of care.

c. Components.

- (1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the

medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2) "d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided. Service documentation shall include narrative documentation and may also include documentation in checkbox format. The service record shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis. For those non-time-related services billed using Current Procedural Terminology (CPT) codes, the total time of the service shall be recorded, rather than the beginning and ending time.
4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5) "c" or "d," 441—paragraph 77.33(6) "d," 441—paragraph 77.34(5) "d," 441—paragraph 77.37(15) "d," 441—paragraph 77.39(13) "e," 441—paragraph 77.39(14) "d," or 441—paragraph 77.46(5) "i," or 441—subparagraph 78.9(10) "a"(1).
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service.
7. The first and last name and professional credentials, if any, of the person providing the service.
8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.
9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise program integrity unit requests providers to submit records for review. (See paragraph 79.4(2) "b.")

- (1) Physician (MD and DO) services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
- (2) Pharmacy services:
 1. Prescriptions.
 2. Nursing facility physician order.
 3. Telephone order.
 4. Pharmacy notes.
 5. Prior authorization documentation.
- (3) Dentist services:
 1. Treatment notes.
 2. Anesthesia notes and records.
 3. Prescriptions.
- (4) Podiatrist services:
 1. Service or office notes or narratives.
 2. Certifying physician statement.
 3. Prescription or order form.
- (5) Certified registered nurse anesthetist services:
 1. Service notes or narratives.
 2. Preanesthesia physical examination report.
 3. Operative report.
 4. Anesthesia record.
 5. Prescriptions.
- (6) Other advanced registered nurse practitioner services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Other service documentation as applicable.
- (7) Optometrist and optician services:
 1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
 2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
 3. Prior authorization documentation.
- (8) Psychologist services:
 1. Service or office psychotherapy notes or narratives.
 2. Psychological examination report and notes.
 3. Other service documentation as applicable.
- (9) Clinic services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Prescriptions.
 5. Medication administration records.
- (10) Services provided by rural health clinics or federally qualified health centers:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
 3. Procedure, laboratory, or test orders and results.

4. Immunization records.
- (11) Services provided by community mental health centers:
 1. Service referral documentation.
 2. Initial evaluation.
 3. Individual treatment plan.
 4. Service or office notes or narratives.
 5. Narratives related to the peer review process and peer review activities related to a member's treatment.
 6. Written plan for accessing emergency services.
 7. Other service documentation as applicable.
- (12) Screening center services:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Laboratory reports.
 4. Results of health, vision, or hearing screenings.
- (13) Family planning services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Nurses' notes.
 4. Immunization records.
 5. Consent forms.
 6. Prescriptions.
 7. Medication administration records.
- (14) Maternal health center services:
 1. Service or office notes or narratives.
 2. Procedure, laboratory, or test orders and results.
 3. Form 470-2942, Prenatal Risk Assessment.
- (15) Birthing center services:
 1. Service or office notes or narratives.
 2. Form 470-2942, Prenatal Risk Assessment.
- (16) Ambulatory surgical center services:
 1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 2. Physician orders.
 3. Consent forms.
 4. Anesthesia records.
 5. Pathology reports.
 6. Laboratory and X-ray reports.
- (17) Hospital services:
 1. Physician orders.
 2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
 3. Progress or status notes.
 4. Diagnostic procedures, including laboratory and X-ray reports.
 5. Pathology reports.
 6. Anesthesia records.
 7. Medication administration records.
- (18) State mental hospital services:
 1. Service referral documentation.
 2. Resident assessment and initial evaluation.
 3. Individual comprehensive treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
 2. Progress or status notes.
 3. Service notes or narratives.
 4. Procedure, laboratory, or test orders and results.
 5. Nurses' notes.
 6. Physical therapy, occupational therapy, and speech therapy notes.
 7. Medication administration records.
 8. Form 470-0042, Case Activity Report.
- (20) Services provided by intermediate care facilities for persons with mental retardation:
1. Physician orders.
 2. Progress or status notes.
 3. Preliminary evaluation.
 4. Comprehensive functional assessment.
 5. Individual program plan.
 6. Form 470-0374, Resident Care Agreement.
 7. Program documentation.
 8. Medication administration records.
 9. Nurses' notes.
 10. Form 470-0042, Case Activity Report.
- (21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
 2. Independent assessment.
 3. Individual treatment plan.
 4. Service notes or narratives (history and physical, therapy records, discharge summary).
 5. Form 470-0042, Case Activity Report.
 6. Medication administration records.
- (22) Hospice services:
1. Physician certifications for hospice care.
 2. Form 470-2618, Election of Medicaid Hospice Benefit.
 3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
 4. Plan of care.
 5. Physician orders.
 6. Progress or status notes.
 7. Service notes or narratives.
 8. Medication administration records.
 9. Prescriptions.
- (23) Services provided by rehabilitation agencies:
1. Physician orders.
 2. Initial certification, recertifications, and treatment plans.
 3. Narratives from treatment sessions.
 4. Treatment and daily progress or status notes and forms.
- (24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
 2. Service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (25) Behavioral health intervention:
1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).
 3. Service notes or narratives.
 4. Other service documentation as applicable.
- (26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
 2. Individualized education program (IEP).
 3. Individual health plan (IHP).
 4. Behavioral intervention plan.
- (27) Home health agency services:
1. Plan of care or plan of treatment.
 2. Certifications and recertifications.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
- (28) Services provided by independent laboratories:
1. Laboratory reports.
 2. Physician order for each laboratory test.
- (29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
 2. Documentation supporting mileage billed.
- (30) Services of lead investigation agencies:
1. Service notes or narratives.
 2. Child's lead level logs (including laboratory results).
 3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
 4. Health education notes, including follow-up notes.
- (31) Medical supplies:
1. Prescriptions.
 2. Certificate of medical necessity.
 3. Prior authorization documentation.
 4. Medical equipment invoice or receipt.
- (32) Orthopedic shoe dealer services:
1. Service notes or narratives.
 2. Prescriptions.
 3. Certifying physician's statement.
- (33) Case management services, including HCBS case management services:
1. Notice of decision for service authorization.
 2. Service notes or narratives.
 3. Social history.
 4. Comprehensive service plan.
 5. Reassessment of member needs.
 6. Incident reports in accordance with 441—subrule 24.4(5).
 7. Other service documentation as applicable.
- (34) Early access service coordinator services:
1. Individualized family service plan (IFSP).
 2. Service notes or narratives.
- (35) Home- and community-based waiver services, other than case management:
1. Notice of decision for service authorization.
 2. Service plan.
 3. Service logs, notes, or narratives.
 4. Mileage and transportation logs.
 5. Log of meal delivery.
 6. Invoices or receipts.

7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
8. Other service documentation as applicable.
- (36) Physical therapist services:
 1. Physician order for physical therapy.
 2. Initial physical therapy certification, recertifications, and treatment plans.
 3. Treatment notes and forms.
 4. Progress or status notes.
- (37) Chiropractor services:
 1. Service or office notes or narratives.
 2. X-ray results.
- (38) Hearing aid dealer and audiologist services:
 1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
 2. Waiver of informed consent.
 3. Prior authorization documentation.
 4. Service or office notes or narratives.
- (39) Behavioral health services:
 1. Assessment.
 2. Individual treatment plan.
 3. Service or office notes or narratives.
 4. Other service documentation as applicable.
- (40) Health home services:
 1. Comprehensive care management plan.
 2. Care coordination and health promotion plan.
 3. Comprehensive transitional care plan, including appropriate follow-up, from inpatient to other settings.
 4. Documentation of member and family support (including authorized representatives).
 5. Documentation of referral to community and social support services, if relevant.
- (41) Services of public health agencies:
 1. Service or office notes or narratives.
 2. Immunization records.
 3. Results of communicable disease testing.
- (42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:
 1. Department-approved standardized neurobehavioral assessment tool.
 2. Community-based neurobehavioral treatment order.
 3. Treatment plan.
 4. Clinical records documenting diagnosis and treatment history.
 5. Progress or status notes.
 6. Service notes or narratives.
 7. Procedure, laboratory, or test orders and results.
 8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
 9. Medication administration records.
 10. Other service documentation as applicable.
- (43) Child care medical services:
 1. Plan of care.
 2. Certification and recertification.
 3. Service notes or narratives.
 4. Physician orders or medical orders.
 5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).

6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

(44) Subacute mental health services.

1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Medication administration records (residential services).

(45) Crisis response services, crisis stabilization community-based services and crisis stabilization residential services.

1. Assessment.
2. Individual stabilization plan.
3. Service notes or narratives (history and physical, therapy records, discharge summary).
4. Medication administration records (residential services).

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) Maintenance requirement. The provider shall maintain records as required by this rule:

- a.* During the time the member is receiving services from the provider.
- b.* For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.
- c.* As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) Availability. Rescinded IAB 1/30/08, effective 4/1/08.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 8262B, IAB 11/4/09, effective 12/9/09; ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0358C, IAB 10/3/12, effective 11/7/12; ARC 0711C, IAB 5/1/13, effective 7/1/13; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2341C, IAB 1/6/16, effective 2/10/16; ARC 3358C, IAB 10/11/17, effective 10/1/17; ARC 3551C, IAB 1/3/18, effective 2/7/18; ARC 3554C, IAB 1/3/18, effective 2/7/18; ARC 3716C, IAB 3/28/18, effective 5/2/18; ARC 4751C, IAB 11/6/19, effective 12/11/19]

441—79.4(249A) Reviews and audits.

79.4(1) Definitions.

“*Authorized representative,*” within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

“*Claim*” means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

“*Clinical record*” means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

“*Confidence level*” means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

“*Customary and prevailing fee*” means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

“*Extrapolation*” means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

“*Fiscal record*” means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

“*Procedure code*” means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

“*Random sample*” means a statistically valid random sample for which the probability of selection for every item in the universe is known.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

“*Universe*” means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records to determine whether:

- (1) The department has correctly paid claims for goods or services.
- (2) The provider has furnished the services to Medicaid members.
- (3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.
- (4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)“*d*” to document the basis for services or activities provided.

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph “*b.*”

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider’s designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) For purposes of these rules, “good cause” has the same meaning as in Iowa Rule of Civil Procedure 1.977.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

f. Self-audit. The department may require a provider to conduct a self-audit and report the results of the self-audit to the department.

79.4(4) Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. *Reevaluation request.* A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. *Additional information.* A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not

previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph “c” of this subrule.

c. Disagreement with sampling results. When the department’s audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department’s sample. Any such audit or review must:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
- (3) Be conducted by a certified public accountant if the issues relate to fiscal records.
- (4) Demonstrate that bills and records that were not audited or reviewed in the department’s sample are in compliance with program regulations.
- (5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records not provided to the department during the review process set forth in subrule 79.4(3) or 79.4(5) shall not be admissible in any subsequent contested case proceeding arising out of a finding and order for repayment of any overpayment identified under subrule 79.4(6). This provision does not preclude providers that have provided records to the department during the review process set forth in subrule 79.4(3) or 79.4(5) from presenting clarifying information or supplemental documentation in the appeals process in order to defend against any overpayment identified under subrule 79.4(6). This provision is intended to minimize potential duplication of effort and delay in the audit or review process, minimize unnecessary appeals, and otherwise forestall fraud, waste, and abuse in the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 0712C, IAB 5/1/13, effective 7/1/13; ARC 1155C, IAB 10/30/13, effective 1/1/14]

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

- 79.6(1)** To maintain clinical and fiscal records as specified in rule 441—79.3(249A).
- 79.6(2)** That the charges as determined in accordance with the department’s policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2) "a"(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. *Recommendations.* Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. *Council.* The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) Procedures.

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B, IAB 11/4/09, effective 12/9/09; ARC 3006C, IAB 3/29/17, effective 6/1/17; ARC 4975C, IAB 3/11/20, effective 4/15/20]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-0829, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-0829 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 16. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4751C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

79.9(7) Incorrect payment.

a. Except as provided in paragraph 79.9(7)“b,” medical assistance funds are incorrectly paid whenever an individual who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

b. Notwithstanding paragraph 79.9(7)“a,” medical assistance funds are not incorrectly paid when an individual who serves as a member's legal representative provides services to the member under a home- and community-based services waiver consumer-directed attendant care agreement or under a consumer choices option employment agreement in effect on or after December 31, 2013. For purposes of this paragraph, “legal representative” means a person, including an attorney, who is authorized by law to act on behalf of the medical assistance program member but does not include the spouse of a member or the parent or stepparent of a member aged 17 or younger.

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and 2014 Iowa Acts, Senate File 2320.
[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1610C, IAB 9/3/14, effective 8/13/14]

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 73.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—79.12(249A) Advance directives. "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 person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving

medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person'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 provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. Iowa Medicaid providers, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise website. Managed care organizations and fiscal agents are exempt from completing an application.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. Providers enrolling as ordering or referring providers shall submit Form 470-5111, Iowa Medicaid Ordering/Referring Provider Enrollment Application.

c. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

d. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

e. An intermediate care facility for persons with an intellectual disability shall also complete the process set forth in 441—subrule 82.3(1).

f. Qualified Medicare beneficiary (QMB) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

g. Health insurance premium payment (HIPP) providers shall enroll using Form 470-5262, Qualified Medicare Beneficiaries (QMB) or Health Insurance Premium Payment (HIPP) Program Provider Enrollment Application.

79.14(2) Submittal of application. The provider shall submit the appropriate application forms, including the application fee, if required, to the Iowa Medicaid enterprise provider services unit by personal delivery, by email, via online enrollment systems, or by mail to P.O. Box 36450, Des Moines, Iowa 50315.

a. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

b. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

c. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

d. Application fees.

(1) Providers who are enrolling or reenrolling in the Iowa Medicaid program shall submit an application fee with their application unless they are exempt as set forth in this paragraph.

(2) Fee amount. The application fee shall be in the amount prescribed by the Secretary of the U.S. Department of Health and Human Services (the Secretary) for the calendar year in which the application is submitted and in accordance with 42 U.S.C. 1395cc(j)(2)(C).

(3) Nonrefundable. The application fee is nonrefundable, except if submitted with one of the following:

1. A hardship exception request that is subsequently approved by the Secretary.

2. An application that is subsequently denied as a result of a temporary moratorium under 2013 Iowa Acts, Senate File 357, section 12.

3. An application or other transaction in which the application fee is not required.

(4) The process for enrolling or reenrolling a provider will not begin until the application fee has been received by the department or a hardship exception request has been approved by the Secretary.

(5) Exempt providers. The following providers shall not be required to submit an application fee:

1. Individual physicians or nonphysician practitioners.

2. Providers that are enrolled in Medicare, another state's Medicaid program or another state's children's health insurance program.

3. Providers that have paid the applicable application fee within 12 months of the date of application submission to a Medicare contractor or another state.

(6) All application fees collected shall be used for the costs associated with the screening procedures as described in subrule 79.14(4). Any unused portion of the application fees collected shall be returned to the federal government in accordance with 42 CFR § 455.460.

79.14(3) Program integrity information requirements.

a. All providers, including but not limited to managed care organizations and Medicaid fiscal agents, applying for participation in the Iowa Medicaid program must disclose all information required to be submitted pursuant to 42 CFR Part 455. In addition, all providers shall disclose any current, or previous, direct or indirect affiliation with a present or former Iowa Medicaid provider that:

(1) Has any uncollected debt owed to Medicaid or any other health care program funded by any governmental entity, including but not limited to the federal and state of Iowa governments;

(2) Has been or is subject to a payment suspension under a federally funded health care program;

(3) Has been excluded from participation under Medicaid, Medicare, or any other federally funded health care program;

(4) Has had its billing privileges denied or revoked;

(5) Has been administratively dissolved by the Iowa secretary of state, or similar action has been taken by a comparable agency in another state; or

(6) Shares a national provider identification (NPI) number or tax ID number with another provider that meets the criteria specified in subparagraph 79.14(3) “a”(1), (2), (3), (4), or (5).

b. The Iowa Medicaid enterprise may deny enrollment to a provider applicant or disenroll a current provider that has any affiliation as set forth in this rule if the department determines that the affiliation poses a risk of fraud, waste, or abuse. Such denial or disenrollment is appealable under 441—Chapter 7 but, notwithstanding any provision to the contrary in that chapter, the provider shall bear the burden to prove by clear and convincing evidence that the affiliation does not pose any risk of fraud, waste, or abuse. The Iowa Medicaid enterprise shall deny enrollment to or shall immediately disenroll any person that the Iowa Medicaid enterprise, Medicare, or any other state Medicaid program has ever terminated under rule 441—79.2(249A) or a similar provision and shall deny enrollment to any person presently suspended from participation, or who would be subject to a suspension, under paragraph 79.2(3) “c.” Further, a person sanctioned under rule 441—79.2(249A) or a similar provision may not manage consumer choices option (CCO) funds for a member.

c. For purposes of this rule, the term “direct or indirect affiliation” includes but is not limited to relationships between individuals, business entities, or a combination of the two. The term includes but is not limited to direct or indirect business relationships that involve:

- (1) A compensation arrangement;
- (2) An ownership arrangement;
- (3) Managerial authority over any member of the affiliation;
- (4) The ability of one member of the affiliation to control or influence any other; or
- (5) The ability of a third party to control or influence any member of the affiliation.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, disenrollment from the medical assistance program is mandatory when, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned, controlled, or directed by a person who (1) has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry; (2) has pled guilty or nolo contendere to, or was convicted of, any crime punishable by a term of imprisonment greater than five years; (3) has, within the last five years, pled guilty or nolo contendere to, or was convicted of, any controlled substance offense; (4) has, within the last ten years, pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty punishable by a term of imprisonment greater than one year but not more than five years; or (5) within the last ten years, has on more than one occasion pled guilty or nolo contendere to, or was convicted of, any crime involving an allegation of dishonesty.

79.14(4) Screening procedures and requirements. Providers applying for participation in the Iowa Medicaid program shall be subject to the “limited,” “moderate,” or “high” categorical risk screening procedures and requirements in accordance with 42 CFR §455.450.

a. For the types of providers that are recognized as a provider under the Medicare program, the Iowa Medicaid enterprise shall use the same categorical risk screening procedures and requirements assigned to that provider type by Medicare pursuant to 42 CFR §424.518.

b. Provider types not assigned a screening level by the Medicare program shall be subject to the procedures of the “limited” risk screening level pursuant to 42 CFR §455.450.

c. Adjustment of risk level. The Iowa Medicaid enterprise shall adjust the categorical risk screening procedures and requirements from “limited” or “moderate” to “high” when any of the following occurs:

(1) The Iowa Medicaid enterprise imposes a payment suspension on a provider based on a credible allegation of fraud, waste, or abuse; the provider has an existing Medicaid overpayment; or within the previous ten years, the provider has been excluded by the Office of the Inspector General or another state’s Medicaid program; or

(2) The Iowa Medicaid enterprise or the Centers for Medicare and Medicaid Services in the previous six months lifted a temporary moratorium for the particular provider type, and a provider that

was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

79.14(5) Notification. A provider shall be notified of the decision on the provider's application within 30 calendar days of receipt by the Iowa Medicaid enterprise provider services unit of a complete and correct application with all required documents, including, but not limited to, if applicable, any application fees or screening results.

79.14(6) A provider that is not approved as the Medicaid provider type requested shall have the right to appeal under 441—Chapter 7.

79.14(7) Effective date of approval. An application shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application with all required documents by the Iowa Medicaid enterprise provider services unit.

79.14(8) A provider approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(9) No payment shall be made to a provider for care or services provided prior to the effective date of the Iowa Medicaid enterprise's approval of an application.

79.14(10) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(11) An amendment to an application shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(12) A provider that has not submitted a claim in the last 24 months will be sent a notice asking if the provider wishes to continue participation. A provider that fails to reply to the notice within 30 calendar days of the date on the notice will be terminated as a provider. Providers that do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(13) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 35 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, telephone number, or any information required to be disclosed by subrule 79.14(3).

a. When a provider reports false, incomplete, or misleading information on any application or reapplication, or fails to provide current information within the 35-day period, the Iowa Medicaid enterprise may immediately terminate the provider's Medicaid enrollment. The termination may be appealed under 441—Chapter 7. Such termination remains in effect notwithstanding any pending appeal.

b. When the department incurs an informational tax-reporting fine or is required to repay the federal share of medical assistance paid to the provider because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine or repayment shall be the responsibility of the individual provider to the extent that the fine or repayment relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine or repayment to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine or repayment may be appealed under 441—Chapter 7.

79.14(14) Provider termination or denial of enrollment. The Iowa Medicaid enterprise must terminate or deny any provider enrollment when the provider has violated any requirements identified in 42 CFR §455.416.

79.14(15) Temporary moratoria. The Iowa Medicaid enterprise must impose any temporary moratorium pursuant to 2013 Iowa Acts, Senate File 357, section 12.

79.14(16) Provider revalidation. Providers are required to complete the application process and screening requirements as detailed in this rule every five years.

79.14(17) Recoupment. A provider is strictly liable for any failure to disclose the information required by subrule 79.14(3) or any failure to report a change required by subrule 79.14(13). The department shall recoup as incorrectly paid all funds paid to the provider before a complete disclosure or report of change was made. The department shall also recoup as incorrectly paid all funds to any provider that billed the Iowa Medicaid enterprise while the provider was administratively dissolved by the Iowa secretary of state or comparable agency of another state, even if the provider subsequently obtains a retroactive reinstatement from the Iowa secretary of state or similar action was taken against the provider by a comparable agency of another state.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11; ARC 0198C, IAB 7/11/12, effective 7/1/12; ARC 0580C, IAB 2/6/13, effective 4/1/13; ARC 1153C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3494C, IAB 12/6/17, effective 1/10/18]

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least \$5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) Policy requirements. Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)“a”;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) Reporting requirements.

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) Enforcement. Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term “hospital-based eligible professional (EP)” as set forth in 42 CFR Section 495.4 as amended to September 4, 2012, the department elects the calendar year preceding the payment year as the period used to gather data to determine whether or not an eligible professional is “hospital-based” for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to September 4, 2012, the department has elected that eligible providers may use either:

(1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to September 4, 2012, or

(2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to September 4, 2012.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,

2. A dentist,

3. A certified nurse midwife,

4. A nurse practitioner, or

5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider that intends to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the CMS Registration and Attestation website, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider's application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment administration website at www.imeincentives.com. The applicant shall use the website to:

- (1) Attest to the applicant's qualifications to receive the incentive payment, and
- (2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.

b. For the second year of participation, eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.

c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) Payment. The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the CMS Registration and Attestation website.

a. The primary communication channel from the department to the provider will be the Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

- (1) Eligibility,
- (2) Purchase of certified electronic health record technology, and
- (3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

[ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 9531B, IAB 6/1/11, effective 5/12/11; ARC 0824C, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded ARC 1056C, IAB 10/2/13, effective 11/6/13.

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- [Filed ARC 1608C (Notice ARC 1520C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
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- [Filed ARC 1697C (Notice ARC 1619C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
- [Filed ARC 1699C (Notice ARC 1617C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
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- [Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
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- [Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
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- [Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
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- ¹ Effective date of 79.1(2) and 79.1(5) “t” delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.
- ² Two ARCs
- ³ Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.
- ⁴ Two or more ARCs
- ⁵ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.
- ⁶ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁷ 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**.
- ⁸ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁹ Two ARCs
- ¹⁰ July 1, 2009, effective date of amendments to 79.1(1) “d,” 79.1(2), and 79.1(24) “a”(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ¹¹ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) “b” (ARC 9959B, IAB 1/11/12).
- ¹² July 1, 2019, effective date of **ARC 4430C** [amendments to chs 78, 79] delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 2019; delay lifted at the meeting held September 10, 2019.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS
WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]

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

441—82.1(249A) Definition.

“Department” means the Iowa department of human services.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermediate care facility for persons with medical complexity” means an intermediate care facility for persons with an intellectual disability which provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4052C, IAB 10/10/18, effective 9/12/18]

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

82.2(1) Governing body and management.

a. Governing body. The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- (1) Exercise general policy, budget, and operating direction over the facility.
- (2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.
- (3) Appoint the administrator of the facility.

b. Compliance with federal, state, and local laws. The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

c. Client records.

(1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients’ health care, active treatment, social information, and protection of the client’s rights.

(2) The facility shall keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

(3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client's record shall make it legibly, date it, and sign it.

(5) The facility shall provide a legend to explain any symbol or abbreviation used in a client's record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client's record.

d. Services provided under agreements with outside sources.

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs "a" to "g," "j," and "k."

e. Disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

82.2(2) Client protections.

a. Protection of clients' rights. The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

b. Client finances.

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

c. Communication with clients, parents, and guardians. The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

d. Staff treatment of clients.

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials 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 shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

82.2(3) Facility staffing.

a. Qualified intellectual disability professional. Each client's active treatment program shall be integrated, coordinated and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3) "b"(5).

b. Professional program services.

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)"b"(5) are not required except for qualified intellectual disability professionals who must meet the requirements set forth in 82.2(3)"a."

c. Facility staffing.

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

d. Direct care (residential living unit) staff.

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly intellectually disabled clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately intellectually disabled clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild intellectual disability, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

e. Staff training program.

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

82.2(4) *Active treatment services.*

a. Active treatment.

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

b. Admissions, transfers, and discharge.

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

c. Individual program plan.

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4) "c"(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. For those clients enrolled with a managed care organization, the client's case manager shall participate as appropriate and as allowed by the client. Participation by the client, the client's parents (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4) "c"(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.

4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.

5. The inappropriate client behaviors, if applicable.

6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.

2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

d. Program implementation.

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

e. Program documentation.

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

f. Program monitoring and change.

(1) The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.

2. Is regressing or losing skills already gained.

3. Is failing to progress toward identified objectives after reasonable efforts have been made.

4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4) "c."

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who

have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.
2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.
3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4) "f"(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

82.2(5) Client behavior and facility practices.

a. Facility practices—conduct toward clients.

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.
4. Be available to all staff, clients, parents of minor children, and legal guardians.

(2) To the extent possible, clients shall participate in the formulation of these policies and procedures.

(3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

b. Management of inappropriate client behavior.

(1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5) "a." These procedures shall:

1. Specify all facility-approved interventions to manage inappropriate client behavior.
2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.
3. Ensure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.

(2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

(3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.

(4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client's individual program plan, in accordance with 82.2(4) "c"(4) and (5).

(5) Standing or as-needed programs to control inappropriate behavior are not permitted.

c. Time-out rooms.

(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

1. The placement is a part of an approved systematic time-out program as required by 82.2(5) "b."

2. The client is under the direct constant visual supervision of designated staff.
3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

- (2) Placement of a client in a time-out room shall not exceed one hour.

- (3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

- (4) A record of time-out activities shall be kept.

d. Physical restraints.

- (1) The facility may employ physical restraint only:

1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.

3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

- (2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.

- (3) The facility shall not issue orders for restraint on a standing or as-needed basis.

- (4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

- (5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

- (6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.

- (7) Barred enclosures shall not be more than three feet in height and shall not have tops.

e. Drug usage.

- (1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.

- (2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.

- (3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

- (4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6) "j," for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

82.2(6) Health care services.

a. Physician services.

- (1) The facility shall ensure the availability of physician services 24 hours a day.

- (2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

- (3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

1. Evaluation of vision and hearing.

2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

b. Physician participation in the individual program plan. A physician shall participate in:

(1) The establishment of each newly admitted client's initial individual program plan.

(2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

c. Nursing services. The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.

2. Be by a licensed nurse.

3. Be on a quarterly or more frequent basis depending on client need.

4. Be recorded in the client's record.

5. Result in any necessary action including referral to a physician to address client health problems.

(4) Other nursing care as prescribed by the physician or as identified by client needs.

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.

2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.

3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

d. Nursing staff.

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

e. Dental services.

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

f. Comprehensive dental diagnostic services. Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

g. Comprehensive dental treatment. The facility shall ensure comprehensive dental treatment services that include:

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

h. Documentation of dental services.

(1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

i. Pharmacy services. The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

j. Drug regimen review.

(1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.

(2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.

(4) An individual medication administration record shall be maintained for each client.

(5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

k. Drug administration. The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

(1) All drugs are administered in compliance with the physician's orders.

(2) All drugs, including those that are self-administered, are administered without error.

(3) Unlicensed personnel are allowed to administer drugs only if state law permits.

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.

(6) No client self-administers medications until the client demonstrates the competency to do so.

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

l. Drug storage and record keeping.

(1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6) "k"(4) may have access to keys to their individual drug supply.

(3) The facility shall maintain records of the receipt and disposition of all controlled drugs.

(4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).

(5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

m. Drug labeling.

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

n. Laboratory services.

(1) For purposes of this subrule, "laboratory" means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

82.2(7) Physical environment.

a. Client living environment.

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

b. Client bedrooms.

- (1) Bedrooms shall:
 1. Be rooms that have at least one outside wall.
 2. Be equipped with or located near toilet and bathing facilities.
 3. Accommodate no more than four clients unless granted a variance under 82.2(7) "b"(3).
 4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.

5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.

(3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disability professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility shall provide each client with:

1. A separate bed of proper size and height for the convenience of the client.
2. A clean, comfortable mattress.
3. Bedding appropriate to the weather and climate.
4. Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

c. Storage space in bedroom. The facility shall provide:

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.

(2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.

d. Client bathrooms. The facility shall:

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.

(2) Provide for individual privacy in toilets, bathtubs, and showers.

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

e. Heating and ventilation.

(1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

f. Floors. The facility shall have:

- (1) Floors that have a resilient, nonabrasive, and slip-resistant surface.
- (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.
- (3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

g. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations

if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

h. Emergency plan and procedures.

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

i. Evacuation drills.

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7) "i"(1) and (2) for any live-in and relief staff they utilize.

j. Fire protection.

(1) General.

1. Except as specified in 82.2(7) "i"(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

k. Paint. The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

l. Infection control.

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

82.2(8) *Dietetic services.*

a. Food and nutrition services.

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

b. Meal services.

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8) "b"(1)"1."

(2) Food shall be served:

1. In appropriate quantity.

2. At appropriate temperature.

3. In a form consistent with the developmental level of the client.

4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

c. Menus.

(1) Menus shall:

1. Be prepared in advance.

2. Provide a variety of foods at each meal.

3. Be different for the same days of each week and adjusted for seasonal change.

4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

d. Dining areas and service. The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

82.3(1) Procedures for establishing health care facilities as Title XIX facilities. All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual."

a. The facility shall obtain the applicable license from 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 department shall transmit an application form and copies of standards to the facility.
d. The facility shall complete its portion of the application form and submit it to the department.
e. The department shall review the application form and forward it to the department of inspections and appeals.

f. 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 terms and conditions of a provider agreement.

k. The department shall review the certification data and:
(1) Transmit the provider agreement as recommended, or
(2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2) "c."

82.3(2) Title XIX provider agreements. The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for persons with an intellectual disability before a provider agreement may be issued. All survey procedures and certification processes 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. Terms of the agreement for facilities without deficiencies are as follows:
(1) The provider agreement shall be issued for a period not to exceed 12 months.
(2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.

b. Terms of the agreement for facilities with deficiencies are as follows:

(1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.

(2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

(3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.

c. The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for persons with an intellectual disability in compliance with rules and regulations of the program.

d. The department may at its option extend an agreement with a facility for two months under either of the following conditions:

(1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.

(2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

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. When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

82.3(3) Appeals of decertification. A facility may appeal a decertification action according to 441—subrule 81.13(28).

This rule is intended to implement Iowa Code section 249A.12.
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.4 Rescinded, effective March 1, 1987.

441—82.5(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

82.5(1) Failure to maintain records. Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.5(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. 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. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.5(3) *Submission of reports.* The facility's cost report shall be received by the Iowa Medicaid enterprise provider cost audit and rate setting unit no later than September 30 each year except as described in subrule 82.5(14).

a. 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 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 82.5(3) "c."

b. 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.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 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.

d. 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 payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability 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 facility may include the cost, but must include sufficient detail so 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.

f. 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.

82.5(4) *Payment at new rate.* When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

82.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.5(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.

82.5(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.

82.5(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member 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.

82.5(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 are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

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.

82.5(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. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. 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.

e. 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 82.5(3)“c.”

(2) Reasonableness—requires that the compensation allowance be such an 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) 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 \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 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 a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(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 as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.5(11)“e”(4) to 82.5(11)“e”(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability 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. If 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 facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. 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, 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 82.5(12).

h. 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.

i. 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 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.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first

entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

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 limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

l. 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.

m. 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 not allowable expenses:

- (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 following conditions 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.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.5(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department 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. 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 home 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 the 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 semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

82.5(13) Assessed fee. The fee assessed pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.5(14), not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.5(14) Payment to new facility. A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted

to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates.

The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14)“*d*,” shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year’s actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

82.5(15) *Payment to new owner.* An existing facility with a new owner shall continue with the previous owner’s per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.5(16) *Payment to existing facilities.* The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

a. Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14)“*d*.”

d. Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

- (1) Administrator's salary.
- (2) Assistant administrator's salary.
- (3) Bookkeeper's salary.
- (4) Other accounting and bookkeeping costs.
- (5) Other clerical salaries and clerical costs.
- (6) Administrative payroll taxes.
- (7) Administrative unemployment taxes.
- (8) Administrative group insurance.
- (9) Administrative general liability and worker's compensation insurance.
- (10) Directors' and officers' insurance or salaries.
- (11) Management fees.
- (12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.
- (13) Legal and professional fees.
- (14) Dues, conferences and publications.
- (15) Postage and telephone.
- (16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.
- (17) Data processing and bank charges.
- (18) Advertising.
- (19) Travel, entertainment and vehicle expenses not directly involving residents.

f. Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.
- (2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.
- (3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).
- (4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

h. State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 0995C, IAB 9/4/13, effective 11/1/13; ARC 2886C, IAB 1/4/17, effective 2/8/17]

441—82.6(249A) Eligibility for services.

82.6(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.6(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.6(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility shall continue as long as a valid need for the care exists.

82.6(4) Rescinded IAB 4/9/97, effective 6/1/97.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.7(249A) Initial approval for ICF/ID care.

82.7(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program shall:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.7(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department shall:

- (1) Approve ICF/ID placement;
- (2) Offer a home- or community-based alternative; or
- (3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.7(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.7(3) Approval of level of care. Medicaid payment shall be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit.

82.7(4) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—16.3(17A).

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 4973C**, IAB 3/11/20, effective 4/15/20]

441—82.8(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the client's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

[**ARC 8207B**, IAB 10/7/09, effective 12/1/09; **ARC 8446B**, IAB 1/13/10, effective 2/17/10; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—82.9(249A) Arrangements with residents.

82.9(1) Resident care agreement. The ICF/ID Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.9(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 Medicaid payment is made. Medicaid 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.

82.9(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. 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 account 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 of inspections and appeals 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, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

82.9(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 the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.10(249A) Discharge and transfer.

82.10(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.10(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.10(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.10(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 or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.10(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.11(249A) Continued stay review. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

441—82.12(249A) Quality of care review. Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

441—82.13(249A) Records.

82.13(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. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.

c. 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.

d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. 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.

g. 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 residents in skilled, intermediate, and residential care.

(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.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.13(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.13(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

441—82.14(249A) Payment procedures.

82.14(1) *Method of payment.* Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

82.14(2) *Payment responsibility.* Rescinded IAB 7/11/12, effective 7/1/12.

82.14(3) Rescinded IAB 8/9/89, effective 10/1/89.

82.14(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 an intermediate care facility for persons with an intellectual disability.

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 to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten 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 visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.14(5) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

82.14(6) Payment for out-of-state care. Rescinded IAB 9/5/90, effective 11/1/90.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.15(249A) Billing procedures.

82.15(1) Claims. Claims for service for clients not enrolled with a managed care organization must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through IME's electronic clearinghouse.

a. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

b. Adjustments to claims may be made electronically as provided for by the Iowa Medicaid enterprise.

82.15(2) Reserved.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.16(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the Iowa Medicaid enterprise for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.17(249A) Audits.

82.17(1) Audits 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—82.5(249A). These 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 agents.

a. When a proper per diem rate cannot be determined, through generally accepted 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 fiscal period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a 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 fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.17(2) *Auditing of proper billing and handling of patient funds.*

a. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department 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 that 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. The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals and representatives of the U.S. Department 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 82.9(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such 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 section 249A.12.
[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—82.18(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.18(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.18(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

82.18(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program.

Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

441—82.19(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability 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 section 249A.30A.
[ARC 0582C, IAB 2/6/13, effective 4/1/13]

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◊ Two or more ARCs

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

[ARC 2471C, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Blind individual” means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

“Deeming” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“Disabled person” means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

“Financial participation” means client participation and medical payments from a third party including veterans’ aid and attendance.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent homemaker service” means homemaker service provided from one to three hours a day for not more than four days per week.

“Intermittent respite service” means respite service provided from one to three times a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Substantial gainful activity” means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

“Third-party payments” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“Usual caregiver” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) Eligibility criteria.

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. Rescinded IAB 1/2/19, effective 2/6/19.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in 441—paragraph 90.4(1) "b."

(2) The IME medical services unit shall be responsible for the initial determination of the member's level of care certification. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2) "b" and 75.5(4) "c" shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) Need for services.

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)“d” and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/ID</u>
\$2,792.65	\$959.50	\$3,742.93

For members enrolled in the health and disability waiver in accordance with subrule 83.2(1), when a member turns 21 years of age, the average monthly cost of services received through 441—subrule 78.9(10) (state plan private duty nursing or personal care services for persons aged 20 and under) shall be used to increase the monthly waiver budget in accordance with the following:

(1) The member must request the revised waiver budget through the member's case manager no earlier than two months before, and no later than six months after, the member's twenty-first birthday. A renewal request must be received annually no earlier than two months before, and no later than six months after, each subsequent birthday.

(2) The member's waiver budget shall be increased by the average monthly cost of state plan private duty nursing or personal care services for the member that was billed to and paid by Iowa Medicaid or an Iowa Medicaid-contracted managed care organization during the year in which the member is 20 years of age.

(3) Once the request is received by the department, the department shall determine the average monthly cost pursuant to the claims data available at the time of the request. No subsequent claims data shall be considered.

(4) The revised waiver budget reflecting the average cost of state plan private duty nursing or personal care services shall become effective on the later of the first day of the month of the member's twenty-first birthday or the first day of the month of the completed review.

(5) The revised waiver budget shall extend up to the first of the month following the member's twenty-fifth birthday and shall remain at the initially authorized amount for the member while aged 21 through 24.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2) “b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4209C, IAB 1/2/19, effective 2/6/19; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant’s name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)“a”(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) Approval of application.

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations are completed.

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4)“a” and “c” do not apply is the date on which the income eligibility and level of care determinations are completed.

c. Eligibility for persons covered under subparagraph 83.2(1)“c”(3) shall exist on the date the income and resource eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

d. Eligibility continues until the member has been in a medical institution for 120 consecutive days for other than respite care. Members who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client’s total income.

83.4(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97. [ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).

[ARC 0757C, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.4(1) “b.” Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the member; and
- b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.

[ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Needed services are not available or received from qualified providers.
- c. Service needs exceed the aggregate monthly costs established in 83.2(2) “b,” or are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—paragraph 130.5(2) “a,” “b,” “c,” “g,” or “h” apply.
- b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2) “b.”
- c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 120 days in any one stay for purposes other than respite care.
- d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member’s own home as determined by the designated case manager.
- e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0757C, IAB 5/29/13, effective 8/1/13; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to 83.20 Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Client participation” means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Interdisciplinary team” means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client’s need for services.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“Specialized respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“Third-party payments” means payments from an individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.
[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) Eligibility criteria. All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.
b. A resident of the state of Iowa.
c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)“b” and 75.5(4)“c” shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) Need for services, service plan, and cost.

a. *Case management.* Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.4(249A) through 441—90.7(249A).

b. *Interdisciplinary team.* The case manager shall establish an interdisciplinary team for the consumer.

(1) *Composition.* The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer’s legal representative, family, service providers, and others directly involved in the consumer’s care.

(2) *Role.* The team shall identify:

1. The consumer’s need for services based on the consumer’s needs and desires.

2. Available and appropriate services to meet the consumer’s needs.

3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.

4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer’s needs change.

c. *Service plan.* An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,792.65	\$1,365.78

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.

2. The funding source for the service.

3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

83.22(3) Providers—standards. Rescinded IAB 10/11/06, effective 10/1/06.

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—83.23(249A) Application.

83.23(1) Application for HCBS elderly waiver. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) Application for services. Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) Approval of application.

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1) "d," indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins.

c. Eligibility continues until the consumer has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which

indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the elderly waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.22(2) “b,” or are not met by services provided.
- d. Needed services are not available or received from qualifying providers.
- e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days in any one stay for purposes other than respite care.
- d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the case manager and the interdisciplinary team.
- e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”

[ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person’s primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to 83.40 Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

“*AIDS*” means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control “Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome,” August 14, 1987, Vol. 36, No. 1S issue of “Morbidity and Mortality Weekly Report.”

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Client participation*” means the amount of the recipient’s income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

“*Deeming*” means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

“*Financial participation*” means client participation and medical payments from a third party including veterans’ aid and attendance.

“*Group respite*” is respite provided on a staff-to-consumer ratio of less than one to one.

“*Guardian*” means a guardian appointed in probate court.

“*HIV*” means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- a. A physician order for all skilled services.
- b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- c. An individualized care plan that identifies support needs.
- d. Confirmation that skilled services are provided to the member.
- e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of medical assistance.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Be diagnosed by a physician as having AIDS or HIV infection.
- b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) The assessment as listed in 83.42(1)“b” shall be completed when the person applies for waiver services, upon request to report a significant change in the person’s condition, and annually for reassessment of the person’s level of care.

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) Need for services.

a. The designated case manager shall review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1) "b" and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of \$1,876.80.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

(3) Rescinded IAB 3/7/01, effective 5/1/01.

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations and the consumer service plan are completed.

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 120 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 120 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical

institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) Maintenance needs of the individual. The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) Limitation on payment. If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) Maintenance needs of spouse and other dependents. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 2361C, IAB 1/6/16, effective 1/1/16]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

- a. The independent support broker selected by the consumer; and
- b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. The client is not eligible for or in need of services.
- b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.
- c. Service needs exceed the aggregate monthly costs established in 83.42(2) “b” or cannot be met by the services provided under the waiver.
- d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph “a,” “b,” “c,” “d,” “g,” or “h” apply.
- b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2) “b.”
- c. The client receives care in a hospital or nursing facility for 120 days or more in any one stay for purposes other than respite care.
- d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client’s own home as determined by the service worker.
- e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs “a” and “b.”
[ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code section 249A.4.

441—83.51 to 83.59 Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

“*Adaptive*” means age-appropriate skills related to taking care of one’s self and one’s ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

“*Adult*” means a person with an intellectual disability aged 18 or over.

“*Appropriate*” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“*Attorney in fact under a durable power of attorney for health care*” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“*Basic individual respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“*Behavior*” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“*Case management services*” means those services established pursuant to Iowa Code chapter 225C.

“*Child*” means a person with an intellectual disability aged 17 or under.

“Client participation” means the posteligibility amount of the consumer’s income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

“Counseling” means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intellectual disability” means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person’s condition was during the developmental period and shall be based on an assessment of the person’s intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

“Intermediate care facility for persons with an intellectual disability (ICF/ID)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided not more than 52 hours per month.

“Maintenance needs” means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

“Managed care” means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified intellectual disability professional” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.
6. A psychologist with a master’s degree in psychology from an accredited school.
7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.
8. A professional recreation staff member with a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.
9. A professional dietitian who is eligible for registration by the American Dietetics Association.
10. A human services professional who must have at least a bachelor’s degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

“*Related condition*” means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

“*Service plan*” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“*SIS assessment*” means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

“*Specialized respite*” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

“*Staff*” means a person under the direction of the organization to perform duties and responsibilities of the organization.

“*Third-party payments*” means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant or a past or present recipient of Medicaid.

“*Usual caregiver*” means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) Eligibility criteria. All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

- (5) Not reside in a medical institution.
 - i.* For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
 - j.* Choose HCBS intellectual disability waiver services rather than ICF/ID services.
 - k.* To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer's family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
 - l.* Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).
 - m.* For residential-based supported community living services, meet all of the following additional criteria:
 - (1) Be less than 18 years of age.
 - (2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:
 1. Social history;
 2. Case history that includes previous placements and service programs;
 3. Medical history that includes major illnesses and current medications;
 4. Current psychological evaluations and consultations;
 5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;
 6. Any current court orders in effect regarding the child;
 7. Any legal history;
 8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;
 9. Whether the proposed placement would be safe for the child and for other children living in that setting; and
 10. Whether the interdisciplinary team is in agreement with the proposed placement.
 - (3) Either:
 1. Be residing in an ICF/ID;
 2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)"a"; or
 3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.
 - n.* For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) Need for services.

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2) “*a*” shall have a department service worker or case manager:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, a SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant’s needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange a SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager’s control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant’s need for service based on the applicant’s needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor’s off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) HCBS intellectual disability waiver program limit. The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person’s name will be put on a waiting list shall be sent to the person by the department.

83.61(4) Securing a payment slot. The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant’s priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4) “b”(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4) “b”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant’s need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2050C, IAB 7/8/15, effective 7/1/15; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker’s control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer’s choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) Effective date of eligibility.

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 120 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which a SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which

indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 2168C, IAB 9/30/15, effective 11/4/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) Development. The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) Retention. The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) Interdisciplinary team meeting. The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of the consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The name of the service provider responsible for providing each service.
- e. The service funding source.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.
- i. For members receiving daily supported community living, day habilitation or adult day care: the following standard scores from the most recently completed SIS assessment:
 - (1) Score on subsection 1A: Exceptional Medical Support Needs.
 - (2) Score on subsection 1B: Exceptional Behavioral Support Needs.
 - (3) Sum total of standard scores on the following subsections:
 1. Subsection 2A: Home Living Activities;
 2. Subsection 2B: Community Living Activities;
 3. Subsection 2E: Health and Safety Activities; and
 4. Subsection 2F: Social Activities.

83.67(5) Documentation. The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) Approval of plan. The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

a. Services must be authorized and entered into ISIS before the plan implementation date.

b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 3481C, IAB 12/6/17, effective 12/1/17; ARC 3790C, IAB 5/9/18, effective 6/13/18]

441—83.68(249A) Adverse service actions.

83.68(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.68(3) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2) paragraph "d," "g," or "h," apply.

b. Needed services are not available or received from qualifying providers.

c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.70(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to 83.80 Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

“Adaptive” means age appropriate skills related to taking care of one’s self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a brain injury aged 18 years or over.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Assessment” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Basic individual respite” means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Brain injury” means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person’s physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.

Malignant neoplasms of brain, parietal lobe.

Malignant neoplasms of brain, occipital lobe.

Malignant neoplasms of brain, ventricles.

Malignant neoplasms of brain, cerebellum.

Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and intraspinal abscess.

Anoxic brain damage.
Subarachnoid hemorrhage.
Intracerebral hemorrhage.
Other and unspecified intracranial hemorrhage.
Occlusion and stenosis of precerebral arteries.
Occlusion of cerebral arteries.
Transient cerebral ischemia.
Acute, but ill-defined, cerebrovascular disease.
Other and ill-defined cerebrovascular diseases.
Fracture of vault of skull.
Fracture of base of skull.
Other and unqualified skull fractures.
Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

“Case management services” means those services established pursuant to Iowa Code chapter 225C.

“Child” means a person with a brain injury aged 17 years or under.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Deemed status” means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

“Department” means the Iowa department of human services.

“Direct service” means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

“Fiscal accountability” means the development and maintenance of budgets and independent fiscal review.

“Group respite” is respite provided on a staff-to-consumer ratio of less than one to one.

“Guardian” means a guardian appointed in probate court.

“Health” means skills related to the maintenance of one’s health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

“Immediate jeopardy” means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily

living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermittent supported community living service” means supported community living service provided from one to three hours a day for not more than four days a week.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical assessment” means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer’s mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Medical intervention” means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer’s care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

“Medical monitoring” means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer’s plan of care.

“Natural supports” means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Organization” means the entity being certified.

“Organizational outcome” means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

“Outcome” means an action or event that follows as a result or consequence of the provision of a service or support.

“Procedures” means the steps to be taken to implement a policy.

“Process” means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

“Qualified brain injury professional” means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years’ experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; licensed clinical social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in human services, social work, psychology, sociology, or public health or rehabilitation services plus 4,000 hours of direct experience with people living with a brain injury.

“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.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which

includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18; ARC 4792C, IAB 12/4/19, effective 1/8/20]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a diagnosis of brain injury.
- b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.
- c. Be at least one month of age.
- d. Be a U.S. citizen and Iowa resident.
- e. Rescinded IAB 7/11/01, effective 7/1/01.
- f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over, the most recent version of the Mayo-Portland Adaptability Inventory (MPAI), and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC), Form 470-4694, and Form 470-5572, the Mayo-Portland Adaptability Inventory (MPAI), are available on request from the member's managed care organization or the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

- g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.
- h. At a minimum, receive a waiver service each quarter in addition to case management.
- i. Choose HCBS.
- j. To be eligible for interim medical monitoring and treatment services the consumer must be:
 - (1) Under the age of 21;
 - (2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);
 - (3) Residing in the consumer's family home or foster family home; and
 - (4) In need of interim medical monitoring and treatment as ordered by a physician.
- k. Receive services in a community, not an institutional, setting.
- l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.
- m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.
- n. For individual supported employment and long-term job coaching services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 - 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 - 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Not reside in a medical institution.
 - (4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.
- o. For small-group supported employment services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 - 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 - 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.
 - (5) Not reside in a medical institution.
- p. For prevocational services:
 - (1) Be at least 16 years of age.
 - (2) The services must not be available to the member through one of the following:
 - 1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or
 - 2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).
 - (3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.
 - (4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) Need for services.

- a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed

before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)“b”(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

d. Applicants who currently reside in a community-based neurobehavioral rehabilitation residential setting, an intermediate care facility for persons with an intellectual disability (ICF/ID), a skilled nursing facility, or an ICF and have resided in that setting for six or more months may request a reserved capacity slot through the brain injury waiver.

(1) Applicants shall be allocated a reserved capacity slot on the basis of the date the request is received by the income maintenance worker or the waiver slot manager.

(2) In the event that more than one request for a reserved capacity slot is received at one time, applicants shall be allocated the next available reserved capacity slot on the basis of the month of birth, January being month one and the lowest number.

(3) Persons who do not fall within the available reserved capacity slots shall have their names maintained on the reserved capacity slot waiting list. As reserved capacity slots become available at the beginning of the next waiver year, persons shall be selected from the reserved capacity slot waiting list to utilize the number of approved reserved capacity slots based on their order on the waiting list.

e. The department shall reserve a set number of funding slots each waiver year for emergency need for all applicants who are on the waiting list maintained by the state on July 1, 2019, and for all new applications received on or after July 1, 2019. Applicants may request an emergency need reserved capacity slot by submitting the completed Home- and Community-Based Services (HCBS) Brain Injury Waiver Emergency Need Assessment, Form 470-5583, to the IME medical services unit.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter, and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the emergency reserved capacity priority waiting list based on the total number of criteria in subparagraph 83.82(4) “e”(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.82(4) “e”(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall remain on the waiting list, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant’s need, the applicant may contact the local department office and request that a new emergency needs assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

f. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2471C, IAB 3/30/16, effective 5/4/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 4792C, IAB 12/4/19, effective 1/8/20; ARC 4974C, IAB 3/11/20, effective 4/15/20]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer’s consent or with the consent of the consumer’s legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer’s legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer’s service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the

consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1) "f," indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the consumer's managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.83(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) Computation of client participation. Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing

eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. For supported community living:
 - (1) The consumer's living environment at the time of waiver enrollment.
 - (2) The number of hours per day of on-site staff supervision needed by the consumer.
 - (3) The number of other waiver consumers who will live with the consumer in the living unit.
- c. An identification and justification of any restriction of a consumer's rights including, but not limited to:
 - (1) Maintenance of personal funds.
 - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the consumer.
- g. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) Use of nonwaiver services. Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

- a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.
- b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate

a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.87(4) Service file. The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to d. Rescinded IAB 8/7/02, effective 10/1/02.

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.88(249A) Adverse service actions.

83.88(1) Denial. An application for services shall be denied when it is determined by the department that:

- a.* The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.
- b.* Service needs exceed the service unit or reimbursement maximums.
- c.* Service needs are not met by the services provided.
- d.* Needed services are not available or received from qualifying providers.
- e.* The brain injury waiver service is not identified in the consumer's service plan.
- f.* There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g.* The consumer receives services from other Medicaid waiver providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph “a” or “b,” apply.

83.88(3) Termination. A particular service may be terminated when the department determines that:

- a.* The provisions of 441—subrule 130.5(2), paragraph “d,” “g,” or “h,” apply.
- b.* Needed services are not available or received from qualifying providers.
- c.* The brain injury waiver service is not identified in the consumer's annual service plan.
- d.* Service needs are not met by the services provided.
- e.* Services needed exceed the service unit or reimbursement maximums.
- f.* Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.
- g.* The consumer receives services from other Medicaid providers.
- h.* The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0191C, IAB 7/11/12, effective 7/1/12; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0359C, IAB 10/3/12, effective 12/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.90(249A) County reimbursement. Rescinded ARC 0191C, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to 83.100 Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

“Adaptive” means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication,

self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

“Adult” means a person with a physical disability aged 18 years to 64 years.

“Appropriate” means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer’s needs, situation, problems, or desires.

“Assessment” means the review of the consumer’s current functioning in regard to the consumer’s situation, needs, strengths, abilities, desires and goals.

“Attorney in fact under a durable power of attorney for health care” means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

“Behavior” means skills related to regulating one’s own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

“Client participation” means the amount of the consumer’s income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

“Department” means the Iowa department of human services.

“Guardian” means a guardian appointed in probate court for an adult.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“Physical disability” means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

“Service plan” means a person-centered, outcome-based plan of services which is written by the member’s case manager with input and direction from the member and which addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member’s legal representative, member’s family, service providers, and others directly involved with the member.

“Skilled nursing facility level of care” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Third-party payments*” means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

“*Waiver year*” means a 12-month period commencing on April 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) Eligibility criteria. All of the following criteria must be met. The person must:

- a. Have a physical disability.
- b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.
- c. Be ineligible for the HCBS intellectual disability waiver.
- d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.
- e. Be eligible for Medicaid under 441—Chapter 75.
- f. Be aged 18 years to 64 years.
- g. Rescinded IAB 2/7/01, effective 2/1/01.
- h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual’s case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

- i. Choose HCBS.
- j. Use a minimum of one unit of service per calendar quarter under this program.
- k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) Need for services.

- a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)“h,” as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed \$705.84 per month.

83.102(3) Slots. The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) County payment slots for persons requiring the ICF/MR level of care. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) Securing a slot.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) Securing a county payment slot. Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) HCBS physical disability waiver waiting list. When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[ARC 9650B, IAB 8/10/11, effective 10/1/11; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.103(249A) Application.

83.103(1) Application for financial eligibility. The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) Approval of application for eligibility.

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h."

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1) "h" and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 120 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.103(4) Attribution of resources. For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the

date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application. [ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) Computation of client participation. Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) Limitation on payment. If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) Information in plan. The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a consumer at the time of waiver program enrollment.
- b. The name of all providers responsible for providing all services.
- c. All service funding sources.
- d. The amount of the service to be received by the consumer.
- e. Whether the consumer has elected the consumer choices option and, if so:
 - (1) The independent support broker selected by the consumer; and
 - (2) The financial management service selected by the consumer.
- f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) Annual assessment. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) "h" and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1) "h" and other supporting documentation as relevant.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care.

The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.107(3) Case file. Rescinded IAB 8/7/02, effective 10/1/02.
[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.108(249A) Adverse service actions.

83.108(1) Denial. An application for services shall be denied when it is determined by the department that:

- a. All of the medically necessary service needs cannot be met in a home- or community-based setting.
- b. Service needs exceed the reimbursement maximums.
- c. Service needs are not met by the services provided.
- d. Needed services are not available or received from qualifying providers.
- e. The physical disability waiver service is not identified in the consumer's service plan.
- f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.
- g. The consumer receives services from other Medicaid waiver providers.
- h. The consumer or legal representative requests termination from the services.

83.108(2) Reduction. A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph "a" or "b," apply.

83.108(3) Termination. A particular service may be terminated when the department determines that:

- a. The provisions of 441—subrule 130.5(2), paragraph "d," "g," or "h," apply.
- b. Needed services are not available or received from qualifying providers.
- c. The physical disability waiver service is not identified in the consumer's annual service plan.
- d. Service needs are not met by the services provided.
- e. Services needed exceed the service unit or reimbursement maximums.
- f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.
- g. The consumer receives services from other Medicaid providers.
- h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

83.109(1) Appeal to county. Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) Reconsideration request to IME medical services unit. Rescinded IAB 9/5/12, effective 11/1/12.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to 83.120 Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

“*Care coordinator*” means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)“b.”

“*Case manager*” means the person designated to provide Medicaid targeted case management services for the consumer.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Consumer*” means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children’s mental health waiver services.

“*Deeming*” means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

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

“*Guardian*” means a parent of a consumer or a legal guardian appointed by the court.

“*HCBS*” means home- and community-based services provided under a Medicaid waiver.

“*IME*” means the Iowa Medicaid enterprise.

“*IME medical services unit*” means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children’s mental health waiver services.

“*Integrated health home*” means the provision of services to enrolled members as described in 441—subrule 78.53(1).

“*Interdisciplinary team*” means the consumer, the consumer’s family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer’s needs, as designated by the consumer and the consumer’s family, who meet to develop a service plan based on the individualized needs of the consumer.

“*ISIS*” means the department’s individualized services information system.

“*Local office*” means a department of human services office as described in 441—subrule 1.4(2).

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Medical institution*” means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

“*Mental health professional*” means a person who meets all of the following conditions:

1. Holds at least a master’s degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

“*Serious emotional disturbance*” means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American

Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless these conditions co-occur with another diagnosable serious emotional disturbance.

"*Service plan*" means a person-centered, outcome-based plan of services that is written by the member's case manager with input and direction from the member and that addresses all relevant services and supports being provided. The service plan is developed by the interdisciplinary team, which includes the member and, if appropriate, the member's legal representative, member's family, service providers, and others directly involved with the member.

"*Skill development*" means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

"*Targeted case management*" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children's mental health waiver.

"*Waiver year*" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2164C, IAB 9/30/15, effective 10/1/15; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3874C, IAB 7/4/18, effective 8/8/18]

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) Age. The consumer must be under 18 years of age.

83.122(2) Diagnosis. The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) Level of care. The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator or managed care organization.

83.122(4) Financial eligibility. The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) Choice of program. The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) Need for service. The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed \$2,006.34 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.
[ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 0548C, IAB 1/9/13, effective 1/1/13; ARC 0665C, IAB 4/3/13, effective 6/1/13; ARC 0842C, IAB 7/24/13, effective 7/1/13; ARC 1056C, IAB 10/2/13, effective 11/6/13; ARC 1445C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 2848C, IAB 12/7/16, effective 11/15/16; ARC 2936C, IAB 2/1/17, effective 3/8/17; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) Program limit. The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1) "a."

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) Approval of waiver eligibility.

a. Time limit. Applications for the HCBS children's mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

(3) The application is pending because the assessment has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

83.123(3) Effective date of eligibility. The effective date of a consumer's eligibility for children's mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) Eligibility review.

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

c. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

83.125(2) Continuation of eligibility. A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 120 or more consecutive days.

(1) After the consumer has spent 120 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 120 consecutive days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) Payment slot. When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

[ARC 2361C, IAB 1/6/16, effective 1/1/16; ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 3184C, IAB 7/5/17, effective 8/9/17]

441—83.128(249A) Adverse service actions.

83.128(1) Denial. An application for children's mental health waiver services shall be denied when the department determines that:

- a.* The consumer is not eligible for or in need of waiver services.
- b.* Needed services are not available or received from qualified providers.
- c.* Service needs exceed the limit on aggregate monthly costs established in 83.122(6) "c" or are not met by the services provided.

83.128(2) Termination. A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

- a.* The provisions of 441—paragraph 130.5(2) "a," "b," "c," "g," or "h" apply.
- b.* The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6) "c."
- c.* The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 120 days in any one stay.
- d.* The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.

e. Service providers are not available.

83.128(3) Reduction. Reduction of services shall apply as specified in 441—paragraphs 130.5(3) “a” and “b.”

[ARC 3184C, IAB 7/5/17, effective 8/9/17; ARC 3234C, IAB 8/2/17, effective 9/6/17]

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7, rule 441—16.3(17A) and rule 441—130.5(234).

[ARC 0306C, IAB 9/5/12, effective 11/1/12; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program and establish requirements for the third-party administrator responsible for the program administration and for the participating health and dental plans that will be delivering services to the enrollees. The purpose of this program is to provide transitional health and dental care coverage to children who are ineligible for Title XIX (Medicaid) assistance as set forth in this chapter. This chapter shall be construed to comply with all requirements for federal funding under Title XXI of the Social Security Act or under the terms of any applicable waiver of Title XXI requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XXI or the terms of any applicable waiver, the requirements of Title XXI or the terms of the waiver shall prevail.

[ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14]

441—86.1(514I) Definitions.

“Applicant” shall mean anyone in the household, including all adults and children under the age of 19 who are counted in the HAWK-I family size according to the modified adjusted gross income methodology and who are listed on the application or renewal form.

“Benchmark benefit package for health care coverage” shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).

2. A health benefits coverage plan that is offered and generally available to state employees in this state.

3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

“Capitation rate” shall mean the fee the department pays monthly to a participating health or dental plan for each enrollee for the provision of covered medical or dental services whether or not the enrollee received services during the month for which the fee is intended.

“Contract” shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health or dental plan for the provision of medical or dental services to HAWK-I enrollees for whom the participating health or dental plans assume risk.

“Cost sharing” shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and Iowa Code section 514I.10.

“Countable income” shall mean earned and unearned income of the family according to the modified adjusted gross income methodology.

“Covered services” shall mean all or a part of those medical and dental services set forth in rule 441—86.14(514I).

“Dentist” shall mean a person who is licensed to practice dentistry.

“Department” shall mean the Iowa department of human services.

“Director” shall mean the director of the Iowa department of human services.

“Eligible child” shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(514I).

“Emergency dental condition” shall mean an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

“Emergency medical condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

“Emergency services” shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical or dental condition.

“Enrollee” shall mean a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

“Enrollment broker” shall mean the entity the department uses to enroll eligible children with a managed care organization. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law.

“Family” shall mean anyone in the household, including all adults and children under the age of 19 who are counted in the HAWK-I family size according to the modified adjusted gross income methodology.

“Federal poverty level” shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

“Good cause” shall mean the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee’s control.
4. There was a failure to receive the third-party administrator’s request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

“HAWK-I board” or *“board”* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

“HAWK-I program” or *“program”* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

“Health insurance coverage” shall mean health insurance coverage as defined in 45 CFR Section 144.103, as amended to October 1, 2008.

“Health Insurance Marketplace” or *“Exchange”* shall mean the entity authorized under 42 U.S.C. Section 18031(d)(4)(F) as amended to April 1, 2013, to evaluate and determine eligibility of applicants for Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs.

“Institution for mental diseases” shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

“Modified adjusted gross income” shall mean the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603 as amended to April 1, 2013.

“Nonmedical public institution” shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, 1994.

“Participating dental plan” shall mean any entity licensed by the division of insurance of the department of commerce to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

“Participating health plan” shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

“Passive enrollment process” shall mean the process by which the department assigns a child to a participating health or dental plan and which seeks to preserve existing provider-enrollee relationships,

if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available health or dental plans.

“*Physician*” shall be defined as provided in Iowa Code subsection 135.1(4).

“*Provider*” shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the HAWK-I program.

“*Third-party administrator*” shall mean the person or entity with which the department contracts to provide administrative services for the HAWK-I program.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8580B, IAB 3/10/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 4779C, IAB 11/20/19, effective 12/25/19]

441—86.2(514I) Eligibility factors. The decision with respect to eligibility shall be based primarily on electronic data matches and information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the HAWK-I program.

86.2(1) Age. The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child’s nineteenth birthday.

86.2(2) Income.

a. Countable income. In determining initial and ongoing eligibility for the HAWK-I program, countable income shall not exceed 302 percent of the federal poverty level for a family of the same size. Countable income shall be determined using the modified adjusted gross income methodology.

b. Verification of income. Income shall be verified through electronic data matches when possible or otherwise verified using the best information available.

(1) Pay stubs, tip records, tax records and employers’ statements are acceptable forms of verification of earned income.

(2) If self-employment income cannot be verified through electronic means, business records or income tax returns from the previous year can be used if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

c. Changes in income. Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child’s eligibility to participate in the HAWK-I program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) Family size. For purposes of establishing initial and ongoing eligibility under the HAWK-I program, the family size shall be determined according to the modified adjusted gross income methodology.

86.2(4) Uninsured status. The child must be uninsured.

a. A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program. However, a child who is enrolled in a plan shall not be considered insured for purposes of the HAWK-I program if:

(1) The plan provides coverage only for a specific disease or service (such as a vision, dental, or cancer policy), or

(2) The child does not have reasonable geographic access to care under that plan. “Reasonable geographic access” means that the plan or an option available under the plan does not have service area limitations or, if the plan has service area limitations, the child lives within 30 miles or 30 minutes of a network primary care provider, or

(3) The child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology. If a child loses eligibility because of such loss of income disregards, the child may be covered under the HAWK-I program for up to 12 months following the loss of Medicaid eligibility regardless of the presence of other health insurance.

b. A child whose health insurance ends in the month of application shall be considered uninsured for purposes of HAWK-I eligibility. However, a one-month waiting period may be imposed pursuant to subrule 86.5(1) for a child who is subject to a monthly premium pursuant to paragraph 86.8(2) “c.”

c. American Indian and Alaska Native. American Indian and Alaska Native children are eligible for the HAWK-I program on the same basis as other children in the state, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

86.2(6) *Iowa residency.* Residency in Iowa is a condition of eligibility for the HAWK-I program. Residency shall be established in accordance with rule 441—75.10(249A).

86.2(7) *Citizenship and immigration status.* To be eligible for the HAWK-I program, the child shall be a citizen or lawfully admitted immigrant. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted immigrant child is eligible to participate in the HAWK-I program.

a. The citizenship or immigration status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for HAWK-I:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration.

(2) When a child under the age of 19 is not living independently, the child’s parent or other responsible person with whom the child lives shall be responsible for attesting to the child’s citizenship or immigration status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2) “f,” applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7) “b” shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2) “d,” “e,” “g,” “h,” and “i.”

d. An applicant or enrollee shall have a reasonable opportunity period to obtain and provide proof of citizenship and nationality in accordance with 441—paragraph 75.11(2) “c.”

e. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the HAWK-I program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. “Nominal amount” shall mean \$10 or less per month.

86.2(9) *Inmates of nonmedical public institutions.* The child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1009 as amended November 10, 1994.

86.2(11) *Furnishing a social security number.* As a condition of eligibility and in accordance with rule 441—75.7(249A), a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under HAWK-I is being requested or received.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 7881B, IAB 7/1/09, effective 7/1/09; ARC 8109B, IAB 9/9/09, effective 10/14/09; ARC 8127B, IAB 9/9/09, effective 9/1/09; ARC 8280B, IAB 11/18/09, effective 1/1/10; ARC 8281B, IAB 11/18/09, effective 12/23/09; ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8838B, IAB 6/16/10, effective 6/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14]

441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply for the HAWK-I program in accordance with rule 441—76.1(249A).

86.3(2) Applications. An application for the HAWK-I program shall be filed in accordance with rule 441—76.1(249A).

86.3(3) Place of filing. An application for the HAWK-I program may be filed with the third-party administrator responsible for making the eligibility determination through an Internet Web site, by telephone, through other electronic means, or in any local or area office of the department of human services, an exchange, disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided.

86.3(4) Date and method of filing. The application is considered filed when received in accordance with rule 441—76.1(249A).

86.3(5) Right to withdraw application. After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application shall be documented, and the applicant shall be sent a notice of decision confirming the request.

86.3(6) Application not required.

a. An application shall not be required when a child becomes ineligible for Medicaid.
b. A new application shall not be required when an eligible child is added to an existing HAWK-I eligible group.

c. A new application shall not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

86.3(7) Information and verification procedure. The decision with respect to eligibility shall be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee and verified through electronic data matches whenever possible.

a. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall be notified in writing of additional information or verification that is required to establish eligibility. The notice may be provided personally, by U.S. mail, by e-mail, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the third-party administrator to secure the information shall serve as a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization shall be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall have 10 working days to supply the information or verification requested. The due date may be extended for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(8) Time limit for decision. Decisions regarding the applicant's eligibility to participate in the HAWK-I program shall be made within 45 working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department. Day one of the 45-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(9) Applicant cooperation. An applicant must cooperate with the third-party administrator in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(10) Waiting lists. When the department has established that all of the funds appropriated for this program are obligated, all subsequent applications for HAWK-I coverage shall be denied unless Medicaid eligibility exists.

a. The department or the third-party administrator shall mail a notice of decision to the applicant that states:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The applicant does not meet eligibility requirements, in which case the applicant shall not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, it must be established that the child is not eligible for Medicaid.

c. Applicants shall be placed on the waiting list on the basis of the date an identifiable application form specified in rule 441—76.1(249A) is received.

(1) In the event that more than one application is received on the same day, applicants shall be placed on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) Any subsequent ties shall be determined by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, applicants shall be selected from the waiting list based on the order in which their names appear on the list and shall be notified of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the applicant's name shall be deleted from the waiting list and the next applicant on the waiting list shall be contacted.

[ARC 8580B, IAB 3/10/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0552C, IAB 1/9/13, effective 4/1/13; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 4779C, IAB 11/20/19, effective 12/25/19]

441—86.4(514I) Coordination with Medicaid.

86.4(1) *HAWK-I applicant eligible for Medicaid.* At the time of initial application, if it is determined the child is eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in the Medicaid program.

86.4(2) *HAWK-I enrollee eligible for Medicaid.* At the time of the annual review, if the child is determined eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in Medicaid effective the first day following the expiration of the 12-month HAWK-I enrollment period.

86.4(3) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child shall be enrolled in the HAWK-I program if otherwise eligible.

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)“a,” coverage shall be effective the first day of the month following the month in which health insurance coverage is lost. Also, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)“c” when the child's health insurance coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

a. The child is moving from Medicaid to HAWK-I.

b. The child has a medical condition that, without medical care, would cause serious disability, loss of function, or death.

c. The cost of health insurance coverage for the child exceeds 5 percent of the family's gross income. The cost of health insurance for the child shall be the difference between the premium for coverage with and without the child.

d. The health insurance was provided through an individual plan.

e. The child's health insurance coverage was lost due to:

(1) Domestic violence.
 (2) Divorce or death of a parent.
 (3) An involuntary loss of employment that qualified the parent for dependent coverage, including but not limited to layoff, business closure, reduction in hours, or termination.

(4) A job change to a new employer that does not offer the parent dependent coverage or that requires a waiting period before children can be enrolled in dependent coverage.

(5) Utilization of the maximum lifetime coverage amount.

(6) Expiration of coverage under COBRA.

(7) Discontinuation of dependent coverage by the parent's employer.

(8) A reason beyond the control of the parent, such as a serious illness of the parent, fire, flood, or natural disaster.

f. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a qualified health plan through the Health Insurance Marketplace because the employer-sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).

g. The cost of family coverage that includes the child exceeds 9.5 percent of the annual household income.

86.5(2) Referrals from Medicaid.

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the HAWK-I program due to cancellation of Medicaid benefits shall be effective the first day of the month after Medicaid eligibility is lost in order to ensure that there is no break in coverage. However, when such a child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

b. EXCEPTION: If the child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology, the child may be covered under the HAWK-I program for up to 12 months following the loss of Medicaid eligibility, regardless of the presence of other health insurance coverage.

86.5(3) Annual renewals. Coverage for children who are determined eligible for the HAWK-I program on the basis of an annual renewal shall be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) Children added to an existing HAWK-I enrollment period. Coverage for children who are determined eligible for the HAWK-I program on the basis of a request from the family to add the child to an existing enrollment period shall be effective the first day of the month following the month in which the request was made. However, if the child does not meet the provisions of paragraph 86.2(4) "a," coverage shall be effective the first day of the month following the month in which health insurance coverage is lost unless the child is subject to a one-month waiting period in accordance with paragraph 86.2(4) "b."

[ARC 8281B, IAB 11/18/09, effective 12/23/09; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 4779C, IAB 11/20/19, effective 12/25/19]

441—86.6(514I) Selection of a plan. Upon the child's eligibility effective date, the child shall be assigned to a health or dental plan using the department's passive enrollment process. The enrollee may change plans only at the time of the annual review unless the provisions of paragraph 86.6(1) "a" or subrule 86.6(2) apply.

86.6(1) Period of enrollment. Once enrolled in a health or dental plan, the child shall remain enrolled in the health or dental plan for a period of 12 months.

a. *Exceptions.* A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child shall be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraph 86.6(1) “b.”

b. Request to change plan. An enrollee may ask to change the health or dental plan either verbally or in writing to the enrollment broker:

(1) Within 90 days following the date of the enrollee’s initial enrollment with the health or dental plan for any reason.

(2) At any time for cause. “Cause” as defined in 42 CFR 438.56(d)(2) as amended to May 6, 2016, includes, but is not limited to:

1. The enrollee moves out of the plan’s service area.
2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.
3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee’s health care needs.

All approved changes shall be made prospectively and shall be effective no later than the first day of the second month beginning after the date on which the change request is received.

86.6(2) *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

86.6(3) *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing to the enrollment broker. The child shall remain enrolled in the current health or dental plan if the family does not notify the enrollment broker of a new health or dental plan choice by the end of the current 12-month enrollment period.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9084B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 4779C, IAB 11/20/19, effective 12/25/19]

441—86.7(514I) Cancellation. The child’s eligibility for the HAWK-I program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) *Child moves from the service area.* Rescinded IAB 1/13/10, effective 3/1/10.

86.7(2) *Age.* The child shall be canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

86.7(3) *Nonpayment of premiums.* The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3) and 86.8(5), unless premiums are subsequently received in accordance with the grace period provisions of subrule 86.8(4).

86.7(4) *Iowa residence abandoned.* The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of 441—subrule 75.10(2).

86.7(5) *Eligible for Medicaid.* The child shall be canceled from the program as of the first day of the month following the month in which Medicaid eligibility is obtained. If there are months during which

the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(6) *Enrolled in other health insurance coverage.* The child shall be canceled from the program as of the first day of the month following the month in which the department or the third-party administrator is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

86.7(7) *Admission to a nonmedical public institution.* The child shall be canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3)“d” apply.

86.7(8) *Admission to an institution for mental disease.* The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(9) *Employment with the state of Iowa.* The child shall be canceled from the HAWK-I program as of the first day of the month in which the child’s parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 4779C, IAB 11/20/19, effective 12/25/19]

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The income considered in determining the premium amount shall be the family’s countable income using the modified adjusted gross income methodology.

86.8(2) *Premium amount.* Except as specified for supplemental dental-only coverage in subrule 86.20(3), premiums under the HAWK-I program shall be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaskan Native; or

(2) The family’s countable income is less than 181 percent of the federal poverty level for a family of the same size.

b. If the family’s countable income is equal to or exceeds 181 percent of the federal poverty level for a family of the same size but does not exceed 242 percent of the federal poverty level for a family of that size, the premium is \$10 per child per month with a \$20 monthly maximum per family.

c. If the family’s countable income is equal to or exceeds 243 percent of the federal poverty level for a family of the same size, the premium is \$20 per child per month with a \$40 monthly maximum per family.

86.8(3) *Due date.*

a. *Payment upon initial application.* “Initial application” means the first program application or a subsequent application that is not a renewal. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. *Payment upon renewal.* “Renewal” means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the department shall notify the health and dental plans of the enrollment.

c. *Subsequent payments.* All subsequent premiums are due by the fifth day of each month for the next month’s coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. Holiday or weekend. When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

86.8(4) Grace period. A grace period shall be allowed on any monthly premium not received as prescribed in paragraph 86.8(3)“c.” The grace period shall be the month immediately following the last month for which the premium has been paid.

a. Failure to submit a premium by the last calendar day of the grace period shall result in disenrollment.

b. If the premium for the grace period and the premium for the following month’s coverage is subsequently received within 45 calendar days following the last calendar day of the grace period, coverage will be reinstated, effective the first day of the calendar month following the grace period, without the need to reapply for coverage.

86.8(5) Method of premium payment. Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the department.

86.8(6) Failure to pay premium. Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in cancellation from the program unless the grace period provisions of subrule 86.8(4) apply. Once a child is canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

86.8(7) Copayment. There shall be a \$25 copayment for each emergency room visit if the child’s medical condition does not meet the definition of emergency medical condition.

EXCEPTION: A copayment shall not be imposed when family income is less than 181 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaskan Native.

[ARC 7770B, IAB 5/20/09, effective 7/1/09; ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14; ARC 2912C, IAB 1/18/17, effective 3/1/17; ARC 4779C, IAB 11/20/19, effective 12/25/19]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program. “Month one” shall be the first month in which coverage is provided.

86.9(1) Review form. A prepopulated review form on which the answers, except for income, have been completed based on the information on file shall be sent to the family. The family shall review the completed information for accuracy and fill in the income section of the form. If family income cannot be verified through electronic data matches, the family shall be required to provide verification of current income. The family shall sign and date the form attesting to its accuracy as part of the review process.

86.9(2) Failure to provide information. The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information shall be acted upon as though they had been received timely. If the fourteenth calendar day falls on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.

86.9(3) Change in plan. Rescinded IAB 1/13/10, effective 3/1/10.
[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8580B, IAB 3/10/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the department or the third-party administrator. “Timely” shall mean no later than ten working days after the change occurred. The ten working-day period begins the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change unless the child is emancipated, married, or otherwise in an independent living situation, in which case the child shall be responsible for reporting the change.

86.10(1) Entry to a nonmedical public institution. The entry of a child into a nonmedical public institution, such as a penal institution, shall be reported following entry to the institution.

86.10(2) Iowa residence is abandoned. The abandonment of Iowa residence shall be reported following the move from the state.

86.10(3) Other insurance coverage. Enrollment of the child in other health insurance coverage shall be reported.

86.10(4) Employment with the state of Iowa. The employment of the child's parent with the state of Iowa shall be reported.

86.10(5) Decrease in income. If the family reports a decrease in income, the third-party administrator shall ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(6) Information reported by a third party. Information reported by a third party shall not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(7) Cooperation. The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(8) Effective date of change in eligibility.

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action shall be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.11(514I) Notice requirements. The applicant shall be provided an adequate written notice of the decision regarding the applicant's eligibility for the HAWK-I program. The enrollee shall be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice shall be timely and adequate as provided in rule 441—16.3(17A).

[ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision to reduce, cancel or deny participation in the HAWK-I program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.

[ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.13(514I) Third-party administrator. The third-party administrator shall have the following responsibilities:

86.13(1) Determination of eligibility. Eligibility for the HAWK-I program shall be determined utilizing the department's eligibility system and in accordance with the provisions of rule 441—86.2(514I).

86.13(2) Dissemination of application forms and information. The third-party administrator shall disseminate the following:

a. Rescinded IAB 10/17/01, effective 12/1/01.

b. Outreach materials, application forms, or other materials developed and produced by the department to any organization or individual making a request for the materials. If the request is

for quantities exceeding ten, the third-party administrator shall forward the request to Iowa prison industries for dissemination.

c. Participating health and dental plan information.

d. Other materials as specified by the department.

86.13(3) *Toll-free dedicated customer services line.* The third-party administrator shall maintain a toll-free multilingual dedicated customer service line in accordance with the requirements of the department.

86.13(4) *HAWK-I program web site.* The third-party administrator shall work in cooperation with the department to maintain a web site providing information about the HAWK-I program.

86.13(5) *Application process.* Applications shall be processed in accordance with the provisions of rule 441—86.3(514I).

a. Processing applications and mailing of approvals and denials shall be completed within ten working days of receipt of the application and all necessary information and verification unless the application cannot be processed within this period for a reason beyond the control of the third-party administrator.

b. Original verification information shall be returned to the applicant or enrollee upon completion of review.

c. Applications shall be screened for completeness. Additional information or verification necessary to establish eligibility may be requested in writing. All information or verification of information attained shall be logged.

d. Health and dental plans shall be notified when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the health or dental plan.

86.13(6) *Effective date of coverage.* The effective date of coverage shall be established in accordance with the provisions of rule 441—86.5(514I).

86.13(7) *Selection of health or dental plan.* The third-party administrator shall provide participating health and dental plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a health or dental plan in accordance with the provisions of rule 441—86.6(514I).

86.13(8) *Enrollment.* The third-party administrator shall notify participating health and dental plans of enrollments.

86.13(9) *Disenrollments.* The third-party administrator shall disenroll an enrollee when the enrollee's eligibility for the HAWK-I program is canceled in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health and dental plans when an enrollee is disenrolled.

86.13(10) *Annual reviews of eligibility.* Eligibility shall be reviewed annually in accordance with the provisions of rules 441—86.2(514I) and 441—86.9(514I).

86.13(11) *Acting on reported changes.* The third-party administrator shall ensure that all changes reported by the HAWK-I enrollee in accordance with rule 441—86.10(514I) are acted upon no later than ten working days from the date the change is reported.

86.13(12) *Premiums.* The third-party administrator shall:

a. Calculate premiums in accordance with the provisions of rule 441—86.8(514I).

b. Collect HAWK-I premium payments. The funds shall be deposited into an interest-bearing account maintained by the department for periodic transmission of the funds and any accrued interest to the HAWK-I trust fund in accordance with state accounting procedures.

c. Track the status of the enrollee premium payments and provide the data to the department.

d. Mail a reminder notice to the family if the premium is not received by the due date.

86.13(13) *Notices to families.* Timely and adequate approval, denial, and cancellation notices that clearly explain the action being taken in regard to an application or an existing enrollment shall be issued to the family. Denial and cancellation notices shall clearly explain the appeal rights of the applicant or enrollee. All notices shall be available in English and Spanish.

86.13(14) Records. The third-party administrator shall at a minimum maintain the following records:

- a. All records required by the department and the department of inspections and appeals.
- b. Records which identify transactions with or on behalf of each enrollee by social security number or other unique identifier.
- c. Application, case and financial records.
- d. All other records as required 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.

86.13(15) Confidentiality. The third-party administrator shall protect and maintain the confidentiality of HAWK-I applicants and enrollees in accordance with 441—Chapter 9.

86.13(16) Reports to the department. The third-party administrator shall submit reports as required by the department.

86.13(17) Systems. The third-party administrator shall maintain data files that are compatible with the department's and the health plans' data files and shall make the system accessible to department staff. [ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.14(514I) Covered services. The benefits provided under the HAWK-I program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act.

86.14(1) Required medical services. The participating health plan shall cover at a minimum the following medically necessary services:

- a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).
- b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).
- c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).
- d. Ambulance services.
- e. Physical therapy.
- f. Nursing care services (including skilled nursing facility services).
- g. Speech therapy.
- h. Durable medical equipment.
- i. Home health care.
- j. Hospice services.
- k. Prescription drugs.
- l. Rescinded IAB 1/13/10, effective 3/1/10.
- m. Hearing services.
- n. Vision services (including corrective lenses).
- o. Translation and interpreter services as specified pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3.
- p. Chiropractic services.
- q. Occupational therapy.

86.14(2) Abortion. Payment for abortion shall only be made under the following circumstances:

- a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.
- b. The pregnancy was the result of an act of rape or incest.

86.14(3) Required dental services. Participating dental plans shall cover at a minimum the following necessary dental services:

- a. Diagnostic and preventive services.

- b. Routine and restorative services.
- c. Endodontic services.
- d. Periodontal services.
- e. Cast restorations.
- f. Prosthetics.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 2912C, IAB 1/18/17, effective 3/1/17]

441—86.15(514I) Participating health and dental plans.

86.15(1) *Licensure.* The participating health or dental plan must:

- a. Be licensed by the division of insurance of the department of commerce to provide health or dental care coverage in Iowa; or
- b. Be an organized delivery system licensed by the director of public health to provide health or dental care coverage.

86.15(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.14(514I) to all children determined eligible.

- a. The participating health or dental plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.
- b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

- c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county in which it is licensed and in which a provider network has been established.

86.15(3) *Premium tax.* Premiums paid to participating health and dental plans by the third-party administrator are exempt from premium tax.

86.15(4) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

86.15(5) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.15(6) *Marketing.*

- a. Participating health and dental plans may not distribute directly or through an agent or independent contractor any marketing materials.
- b. All marketing materials require prior approval from the department.
- c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

- (1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the HAWK-I enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

- (2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the health or dental plan and shall be made available to the third-party administrator for distribution.

- d. All health and dental plan literature and brochures shall be approved by the department.
- e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.15(7) *Appeal process.* The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

- a.* Is approved by the department prior to use.
- b.* Acknowledges receipt of the appeal to the enrollee.
- c.* Establishes time frames which ensure that appeals be resolved within 45 days, except for appeals which involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.
- d.* Ensures the participation of persons with authority to take corrective action.
- e.* Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.
- f.* Ensures the confidentiality of the enrollee.
- g.* Ensures issuance of a written decision to the enrollee for each appeal which shall contain an adequate explanation of the action taken and the reason for the decision.
- h.* Maintains a log of the appeals which is made available to the department at its request.
- i.* Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.
- j.* Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.15(8) *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

86.15(9) *Records and reports.* The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

- (1) Identifies each medical or dental record by HAWK-I enrollee identification number.
- (2) Maintains a complete medical or dental record for each enrollee.
- (3) Provides a specific medical or dental record on demand.
- (4) Meets state and federal reporting requirements applicable to the HAWK-I program.
- (5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services which are infrequently used, which provide a support system service to the operation of the health or dental plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.15(2) "b."

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a “need to know” on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

- (1) A list of providers of services under the plan.
- (2) Encounter data on a monthly basis as required by the department.
- (3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

- (1) Information regarding the plan’s appeal process.
- (2) A plan for a health improvement program.
- (3) Periodic financial, utilization and statistical reports as required by the department.
- (4) Time-specific reports which define activity for child health care, appeals and other designated activities which may, at the department’s discretion, vary among plans, depending on the services covered or other differences.

- (5) Other information as directed by the department.

86.15(10) *Systems.* The participating health or dental plan shall maintain data files that are compatible with the department’s and third-party administrator’s systems.

86.15(11) *Payment to the participating health or dental plan.*

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

86.15(12) *Quality assurance.* The health or dental plan shall have in effect an internal quality assurance system.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.16(514I) Clinical advisory committee. Members of the clinical advisory committee established in accordance with the provisions of 441—paragraph 1.10(2) “c” shall be appointed to three-year terms. Members may be appointed for more than one term. No more than one-third of the membership of the committee shall rotate off the committee in any given calendar year.

441—86.17(514I) Use of donations to the HAWK-I program. If an individual or other entity makes a monetary donation to the HAWK-I program, the department shall deposit the donation into the HAWK-I trust fund. The department shall track all donations separately and shall not commingle the donations

with other moneys in the trust fund. The department shall report the receipt of all donations to the HAWK-I board.

86.17(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.17(2) If the donation is less than \$5,000 and the donor does not specifically identify how it is to be used, the department shall use the moneys in the following order:

- a. For the direct benefit of enrollees (e.g., premium payments).
- b. For outreach activities.
- c. For other purposes as determined by the HAWK-I board.

86.17(3) If the donation is more than \$5,000 and the donor does not specify how the funds are to be used, the HAWK-I board shall determine how the funds are to be used.

441—86.18(505) Health insurance data match program. All carriers, as defined in Iowa Code section 514C.13, shall enter into an agreement with the department to provide data necessary to allow the department to comply with the mandate of Iowa Code section 505.25. Each carrier shall either:

1. Enter into and maintain an agreement with the department on Form 470-4435, HAWK-I Data Use Agreement; or
2. Provide proof of an existing agreement with the department or the department's designee.

441—86.19(514I) Recovery.

86.19(1) Definitions.

“Administrative error” means an action of the department or the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the department or the HAWK-I third-party administrator.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.

“Client error” means any action or inaction of the enrollee or the enrollee's representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee's representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee's representative failed to timely report a change as defined in rule 441—86.10(514I).

86.19(2) Amount subject to recovery from the enrollee or representative. The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

- a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.
- b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.19(3) Notification. The enrollee shall be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

- a. The name of the person for whom funds were incorrectly paid;
- b. The period during which the funds were incorrectly paid;
- c. The amount subject to recovery; and
- d. The reason for the incorrect payment.

86.19(4) Recovery.

- a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

- b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

- c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.19(5) Appeals. The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 8839B, IAB 6/16/10, effective 8/1/10; ARC 0552C, IAB 1/9/13, effective 4/1/13; ARC 0837C, IAB 7/24/13, effective 10/1/13]

441—86.20(514I) Supplemental dental-only coverage.

86.20(1) Definition.

“*Supplemental dental-only coverage*” means dental care coverage provided to a child who meets the eligibility requirements for the HAWK-I program except that the child is covered by health insurance through an individual or group health plan.

86.20(2) Eligibility. Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.1(514I) through 441—86.12(514I), 441—86.18(514I), and 441—86.19(514I).

86.20(3) Premiums. Premiums for participation in the supplemental dental-only plan are assessed as follows:

- a. No premium is charged to families who meet the provisions of subparagraph 86.8(2) “a”(1) or to families whose countable income is less than or equal to 167 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology.

- b. If the family's countable income is equal to or exceeds 168 percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is \$5 per child per month with a \$10 monthly maximum per family.

- c. If the family's countable income exceeds 203 percent of the federal poverty level but does not exceed 254 percent of the federal poverty level for a family of the same size, the premium is \$10 per child per month with a \$15 monthly maximum per family.

- d. If the family's countable income exceeds 254 percent of the federal poverty level for a family of the same size, the premium is \$15 per child per month with a \$20 monthly maximum per family.

- e. If the family includes uninsured children who are eligible for both medical and dental coverage under HAWK-I and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:

(1) The total premium shall be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under HAWK-I because they are covered by health insurance.

f. The provisions of subrules 86.8(3) to 86.8(6) apply to premiums specified in this subrule.

86.20(4) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.

[ARC 8478B, IAB 1/13/10, effective 3/1/10; ARC 9083B, IAB 9/22/10, effective 9/1/10; ARC 0837C, IAB 7/24/13, effective 10/1/13; ARC 1287C, IAB 1/8/14, effective 1/1/14; ARC 2912C, IAB 1/18/17, effective 3/1/17; ARC 4779C, IAB 11/20/19, effective 12/25/19]

These rules are intended to implement Iowa Code chapter 514I as amended by 2009 Iowa Acts, Senate File 389.

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CHAPTER 90
CASE MANAGEMENT SERVICES

Case management services are designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services. The term “case management” encompasses all categories of case management: targeted case management, case management and administrative case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children’s mental health waiver populations. If a part of these rules does not apply to all categories of case management, then the rule will clarify the affected category(ies).

[ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—90.1(249A) Definitions.

“*Adult*” means a person 18 years of age or older on the first day of the month in which service begins.

“*Applicant*” means a person who has applied for an HCBS waiver or habilitation program.

“*Care coordination*” means the case management services provided by an integrated health home to members who are also receiving home- and community-based habilitation services pursuant to rule 441—78.27(249A) or HCBS children’s mental health waiver services pursuant to rules 441—83.121(249A) through 441—83.129(249A).

“*Case management*” means the categories of case management: targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination provided to the habilitation and children’s mental health waiver populations.

“*Case manager*” means the staff person providing all categories of case management services regardless of the entity providing the service or the program in which the member is enrolled, including IHH care coordination.

“*Child*” means a person other than an adult.

“*Chronic mental illness*” means a condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment. The definition of chronic mental illness and qualifying criteria are found at rule 441—24.1(225C). For purposes of this chapter, people with mental disorders resulting from Alzheimer’s disease or substance abuse shall not be considered chronically mentally ill.

“*Community-based case manager*” means the employee of a Medicaid-contracted managed care organization (MCO) who provides case management services to MCO-enrolled members.

“*Core standardized assessment*” or “*CSA*” means an assessment instrument for determining the suitability of non-institutionally based long-term services and supports for an individual. The instrument shall be used in a uniform manner throughout the state to determine an applicant’s or member’s needs for training, support services, medical care, transportation, and other services and to develop an individual service plan to address such needs. The core standardized assessment shall be performed by a contractor under the direction of the department for the fee-for-service population. MCOs shall perform core standardized assessments for MCO-enrolled members or shall delegate the responsibility for completion of assessments. 441—Chapter 83 designates the assessment and reassessment tools to be used for each HCBS waiver. 441—Chapter 78 designates the assessment and reassessment tools to be used for habilitation.

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

“*Developmental disability*” means a severe, chronic disability that is determined through professionally administered screening and evaluations and that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;

3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care, (b) receptive and expressive language, (c) learning, (d) mobility, (e) self-direction, (f) capacity for independent living, and (g) economic self-sufficiency; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Fee-for-service member" or *"FFS member"* means a member who is not enrolled with a managed care organization because the member is exempt from managed care organization enrollment.

"Home- and community-based services" or *"HCBS"* means services provided pursuant to Sections 1915(c) and 1915(i) of the Social Security Act.

"Integrated health home" or *"IHH"* means a provider of health home services that is a Medicaid-enrolled provider and that is determined through the provider enrollment process to have the qualifications, systems and infrastructure in place to provide IHH services pursuant to rule 441—77.47(249A). IHH covered services and member eligibility for IHH enrollment are also governed by rule 441—78.53(249A) and the health home state plan amendment. The IHH provides care coordination services for enrolled habilitation and children's mental health waiver members.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder). Diagnosis criteria are outlined in rule 441—83.61(249A).

"Major incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and 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, a report of dependent adult abuse pursuant to Iowa Code section 235B.3, or a report of elder abuse pursuant to Iowa Code chapter 235F; or
6. Involves a member's location being unknown by provider staff who are responsible for protective oversight.

"Managed care organization" or *"MCO"* means the same as defined in rule 441—73.1(249A).

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in the most recent amendment to 42 Code of Federal Regulations Section 435.1009. A residential care facility is not a medical institution.

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

"Minor incident" means an occurrence that involves a member who is enrolled in an HCBS waiver, targeted case management, or habilitation services and that is not a major incident but 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.

"Person-centered service plan" or *"service plan"* means a service plan created through the person-centered planning process, directed by the member with long-term care needs or the member's guardian or representative, to identify the member's strengths, capabilities, preferences, needs, and desired outcomes.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a member may share a residence.

“*Targeted case management*” means case management services furnished to assist members who are part of a targeted population.

“*Targeted population*” means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of intellectual disability, chronic mental illness, or developmental disability; or
2. A child who is eligible to receive HCBS intellectual disability waiver services or HCBS children’s mental health waiver services according to 441—Chapter 83.

A member enrolled with a managed care organization or integrated health home is not part of the targeted population.

[ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—90.2(249A) Targeted case management. Rule 441—90.2(249A) applies only to the case management category of targeted case management and the defined targeted population.

90.2(1) Eligibility for targeted case management. A person who meets all of the following criteria shall be eligible for targeted case management:

- a. The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35);
- b. The person is a member of a targeted population;
- c. The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.2(4);
- d. The person has applied for targeted case management in accordance with the policies of the provider;
- e. The person’s need for targeted case management has been determined in accordance with rule 441—90.2(249A); and
- f. The person is not eligible for, or enrolled in, Medicaid managed care.

90.2(2) Determination of need for targeted case management. Assessment at least every 365 days of the need for targeted case management is required as a condition of eligibility under the medical assistance program. The targeted case management provider shall determine the member’s initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member’s file and shall demonstrate that all of the following criteria are met:

- a. The member has a need for targeted case management to manage necessary medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member;
- b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services; and
- c. The member is not receiving, under the medical assistance program or under a Medicaid managed health care plan, other paid benefits that serve the same purpose as targeted case management or integrated health home care coordination.

90.2(3) Application for targeted case management. The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department’s service unit or mental health and disability services regions if other services outside the scope of case management are needed or requested.

a. *Application process and documentation.* The application shall include the member’s name, the nature of the request for services, and a summary of any evaluation activities completed. For FFS members, the provider shall inform the applicant in writing of the applicant’s right to choose the provider of case management services and, at the applicant’s request, shall provide a list of other case management services agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

b. *Application decision for targeted case management.* The case manager shall inform the applicant, or the applicant’s guardian or representative, of any decision to approve, deny, or delay the service in accordance with the notification requirements at rule 441—16.3(17A).

c. *Denial of applications.* The case manager shall deny an application for service when:

- (1) The applicant is not currently eligible for Medicaid;

- (2) The applicant does not meet the eligibility criteria in 441—subrule 90.2(1);
- (3) The applicant, or the applicant’s guardian or representative, withdraws the application;
- (4) The applicant does not provide information required to process the application;
- (5) The applicant is receiving duplicative targeted case management or integrated health home care coordination from another Medicaid provider; or
- (6) The applicant does not have a need for targeted case management.

90.2(4) Transition to a community setting. Managed care organizations must provide transition services to all enrolled members. Fee-for-service targeted case management services may be provided to a member transitioning to a community setting during the 60 days before the member’s discharge from a medical institution when the following requirements are met:

- a. The member is an adult who qualifies for targeted case management and is a member of a targeted population. Transitional case management is not an allowable service for other HCBS programs or populations;
- b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning;
- c. The amount, duration, and scope of case management services shall be documented in the member’s service plan, which must include case management services before and after discharge, to facilitate a successful transition to community living;
- d. Payment shall be made only for services provided by Medicaid-enrolled targeted case management providers; and
- e. Claims for reimbursement for case management services shall not be submitted until the member’s discharge from the medical institution and enrollment in community services.

[ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—90.3(249A) Termination of targeted case management services. Rule 441—90.3(249A) applies only to the case management category of targeted case management and the defined targeted population.

90.3(1) Targeted case management shall be terminated when:

- a. The member does not meet eligibility criteria under rule 441—90.2(249A);
- b. The member has achieved all goals and objectives of the service;
- c. The member has no ongoing need for targeted case management;
- d. The member is receiving targeted case management based on eligibility under an HCBS program but is no longer eligible for the program;
- e. The member or the member’s guardian or representative requests termination;
- f. The member is unwilling or unable to accept further services; or
- g. The member or the member’s guardian or representative fails to provide access to information necessary for the development of the service plan or for implementation of targeted case management.

90.3(2) The provider shall notify the member or the member’s guardian or representative in writing of the termination of targeted case management, in accordance with rule 441—16.3(17A).

[ARC 4897C, IAB 2/12/20, effective 3/18/20; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—90.4(249A) Case management services. Rule 441—90.4(249A) applies to all categories of case management and all populations covered by case management.

90.4(1) Covered services. The following shall be included in case management services provided to members, whether FFS members or MCO-enrolled members:

- a. *Assessment.* Initial assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The assessments and reassessments shall address all of the applicant’s and member’s areas of need, strengths, preferences, and risk factors, considering the person’s physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each waiver population and 441—Chapter 78 for the habilitation population. Initial assessments must be face to face. Reassessments using the interRAI must be done face to face. Only the Supports

Intensity Scale® assessment can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD). The off-year assessment (OYA) for the intellectual disability waiver can be done telephonically. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the applicant or member; the case manager does not assume the role of the assessor.

b. Person-centered service plan. At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, guardians, representatives, and others as necessary to form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan.

(1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled or 441—Chapter 78 for members enrolled in habilitation.

(2) Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include:

1. The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.

2. The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable.

3. Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process.

5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs.

6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.

7. The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.

9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.

11. The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used.

12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.

13. The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.

14. The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices.

15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.

(3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall:

1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative.

3. Note the strengths-based positive attributes of the member at the beginning of the plan.

4. Identify risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality of life concepts important to the member.

6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.

7. Document the specific person or persons, provider agency and other entities providing services and supports.

8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.

9. Document non-paid supports and items needed to achieve the goals.

10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardians or representatives, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.

11. Identify each person and entity responsible for monitoring the plan's implementation.

12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member.

13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).

14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen.

15. Be distributed directly to all parties involved in the planning process.

c. Referral and related activities. The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting the

member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the person-centered service plan.

d. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home, when applicable), and all services regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:

(1) Services are being furnished in accordance with the member's person-centered service plan, including the amount of service provided and the member's attendance and participation in the service;

(2) The member has declined services in the service plan;

(3) Communication among providers is occurring, as practicable, to ensure coordination of services;

(4) Services in the person-centered service plan are adequate, including the member's progress toward achieving the goals and actions determined in the person-centered service plan; and

(5) There are changes in the needs or circumstances of the member. Follow-up activities shall include making necessary adjustments in the person-centered service plan and service arrangements with providers.

e. Contacts. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:

(1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly;

(2) The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone;

(3) Community-based case management contacts will be made in accordance with the Medicaid contract MED-16-019, or subsequent Medicaid managed care contracts with the department, in those instances where the contract specifies contacts different from this rule.

90.4(2) Exclusions. Payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs;

(2) Public guardianship programs;

(3) Special education programs;

(4) Child welfare and child protective services; or

(5) Foster care programs.

c. The activities are components of the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program;

(2) Assessing adoption placements;

(3) Recruiting or interviewing potential foster care parents;

(4) Serving legal papers;

(5) Conducting home investigations;

(6) Providing transportation related to the administration of foster care;

(7) Administering foster care subsidies; or

(8) Making placement arrangements.

d. The activities for which a member may be eligible are a component of the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.
[ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—90.5(249A) Rights restrictions. Rule 441—90.5(249A) applies to all categories of case management and all populations covered by case management. Any effort to restrict the rights of a member to realize the member's preferences or goals must be justified by a specific individualized assessed safety need and documented in the person-centered service plan. The following requirements must be documented in the plan when a safety need has been identified that warrants a rights restriction:

1. The specific and individualized assessed safety need;
2. The positive interventions and supports used prior to any modifications or additions to the person-centered service plan regarding safety needs;
3. The less intrusive methods of meeting the safety needs that have been tried but were not successful;
4. A clear description of the rights restriction that is directly proportionate to the specific assessed safety need;
5. The regular collection and review of data to measure the ongoing effectiveness of the rights restriction;
6. The established time limits for periodic reviews to determine whether the rights restriction is still necessary or can be terminated;
7. The informed consent of the member to the proposed rights restriction; and
8. An assurance that the rights restriction itself will not cause undue harm to the member.

[ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—90.6(249A) Documentation and billing.

90.6(1) Documentation of contacts. Subrule 90.6(1) applies to all categories of case management and all populations covered by case management.

- a. Documentation of case management services contacts shall include:
- (1) The name of the individual case manager;
 - (2) The need for, and occurrences of, coordination with other case managers within the same agency or referral or transition to another case management agency; and
 - (3) Other requirements as outlined in rule 441—79.3(249A) to support payment of services.
- b. Targeted case management providers serving FFS members must also adhere to 441—subrule 24.4(4).

90.6(2) Rounding units of service for case management services. Subrule 90.6(2) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. For all fee-for-service case management units of service, the following rounding process shall be used:

- a. Add together the minutes spent on all billable activities during a calendar day for a daily total;
- b. For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day;
- c. Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit; and
- d. Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

90.6(3) Collateral contacts. Subrule 90.6(3) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. For all fee-for-service case management units of service, the case manager may bill for documented contacts with other entities and individuals if the contacts are directly related to the member's needs and care,

such as helping the member access services, identifying needs and supports to assist the member in obtaining services, providing other case managers with useful feedback, and alerting other case managers to changes in the member's needs.

90.6(4) Billable activities for case management services. Subrule 90.6(4) applies only to targeted case management provided to FFS members or case management provided to brain injury or elderly waiver FFS members. Billable activities for case management services are limited to the following activities, and any activity included in this list must be billed if the activity has occurred.

- a. Face-to-face meeting with the member:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- b. Telephone conversation with the member:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- c. Collateral contacts on behalf of the member, including face-to-face, telephone, and email contacts:
 - (1) Contact time; and
 - (2) Documentation completed during meeting.
- d. Individual care plans and person-centered service plans:
 - (1) Creation; and
 - (2) Revision.
- e. Social histories:
 - (1) Creation; and
 - (2) Revision.
- f. Assessments and reassessments:
 - (1) Participation during the assessment if requested by the member; and
 - (2) Utilization of the assessment for creation of the person-centered service plan.

[ARC 4897C, IAB 2/12/20, effective 3/18/20]

441—90.7(249A) Case management services provider requirements. Rule 441—90.7(249A) applies to all categories of case management and all populations covered by case management.

90.7(1) Reporting procedures for major incidents.

- a. When a major incident occurs or a staff member becomes aware of a major incident:
 - (1) The staff member shall notify the following persons of the incident by midnight of the next calendar day after the incident:
 - 1. The staff member's supervisor;
 - 2. The member or member's legal guardians; and
 - 3. The member's case manager. The case manager shall create an incident report if a provider has not submitted a report.
 - (2) By midnight of the next business 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 by the staff member about the incident to the member's managed care organization in the format required by the managed care organization. If the member is not enrolled with a managed care organization, or is receiving money follows the person funding, the staff member shall report the information by direct data entry into the Iowa Medicaid portal access (IMPA) system. The case manager is responsible for reporting the incident if the provider of service has not already reported the incident.
 - (3) The following information shall be reported:
 - 1. The name of the member involved;
 - 2. The date, time, and location where 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 Medicaid-eligible members

or non-Medicaid-eligible persons who were present must be maintained by the use of initials or other means;

5. The action taken to manage or respond to the incident;
6. The resolution of or follow-up to the incident; and
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) When complete information about the incident is not available at the time of the initial report, the case management services provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up.

(5) The case management services provider shall maintain the completed report in a centralized file with a notation in the member's file.

(6) The case management services provider shall track incident data and analyze trends to assess the health and safety of members served and to determine whether changes need to be made for service implementation or whether staff training is needed to reduce the number or severity of incidents.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation to ensure that the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the service plan in order to ensure the continued health, safety, and welfare of the member. Documentation must be made in the person-centered service plan of this review and follow-up activities.

90.7(2) Reporting procedures for minor incidents. Minor incidents may be reported in any format designated by the case management services 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.

90.7(3) Quality assurance. Case management services providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise or a Medicaid managed care organization, as well as any other state or federal entity with oversight authority to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

- a. Postpayment review of case management services;
- b. Review of incident reports;
- c. Review of reports of abuse or neglect; and
- d. Technical assistance in determining the need for service.

[ARC 4897C, IAB 2/12/20, effective 3/18/20]

These rules are intended to implement Iowa Code section 249A.4.

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¹ January 1, 2003, effective date of 90.2(5) and 90.3 delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.

CHAPTER 91
MEDICARE DRUG SUBSIDY

PREAMBLE

Public Law 108-173, the Medicare Modernization Act of 2003, created a prescription drug benefit for Medicare beneficiaries (Medicare Part D) and a subsidy to reduce or eliminate costs associated with the Medicare drug benefit for persons with limited income and resources. The Act requires both the federal Social Security Administration and state Medicaid agencies to accept and adjudicate subsidy applications. The Social Security Administration refers to the subsidy as “extra help for Medicare prescription drug costs.” This chapter implements procedures for the department of human services, the state Medicaid agency in Iowa, to carry out these duties.

441—91.1(249A) Definitions. As used in this chapter:

“*Applicant*” means a person applying for a Medicare drug subsidy through the department and includes a responsible person or authorized representative acting for an applicant, except for the purposes of subrule 91.2(2).

“*Application*” or “*Medicare drug subsidy application*” means the federal Social Security Administration’s Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs, accompanied by the department’s Form 470-4159, Authorization for Department to Process.

“*Authorized representative*” means a person representing an applicant or recipient as described in 441—paragraph 76.1(7)“*b.*”

“*Department*” means the Iowa department of human services and includes any local office of the department.

“*Local office*” means a department office as described in 441—subrule 1.4(2).

“*Recipient*” means a person receiving a Medicare drug subsidy based on an application filed with the department and includes a responsible person or authorized representative acting for a recipient, except for the purposes of subrule 91.2(2).

“*Responsible person*” means a person acting on an applicant’s or recipient’s behalf as described at 441—paragraph 76.1(7)“*a.*”

441—91.2(249A) Application. Any person may apply for the Medicare drug subsidy through the department.

91.2(1) Date, method, and place of filing. An application is considered filed on the date an identifiable signed application is received and date-stamped in any local office.

a. When an application is delivered to a closed local office, the application will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open.

b. A copy of an application received by fax shall be given the same effect as the original application.

91.2(2) Identifiable application and signature.

a. An identifiable application is an application that contains:

(1) The legible name and address of the applicant; and

(2) The signature of the applicant, a responsible person, or an authorized representative on both Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs, and Form 470-4159, Authorization for Department to Process.

b. If an authorized representative signed the application forms on behalf of an applicant, the applicant or a responsible person must also sign the application forms before the application can be approved.

91.2(3) Right to withdraw. After an application has been filed, the applicant may withdraw the application at any time before the eligibility determination.

a. The applicant may request that the application be withdrawn entirely or may, before the date the application is processed, request withdrawal for any month covered by the application.

b. The local office shall send a Notice of Decision, Form 470-0485, 470-0486, 470-0486(S), or 470-0490, to the applicant confirming the request to withdraw the application.

441—91.3(249A) Eligibility determination. The department shall determine eligibility for the Medicare drug subsidy pursuant to Section 1860D-14 of the Social Security Act and implementing federal regulations at 20 CFR Part 418. The department shall base decisions with respect to initial and ongoing eligibility primarily on information furnished by the applicant or recipient.

91.3(1) Cooperation. An applicant must cooperate with the department in the application process. Cooperation may include providing additional information or verification of information, participating in an interview, or signing documents. Failure to cooperate in the application process shall be a basis for denial of an application.

91.3(2) Additional information and verification. The department shall notify the applicant or recipient in writing of any additional information or verification that is required to maintain or establish eligibility. This notice shall be delivered to the applicant or recipient by personal delivery, mail, or facsimile transmission.

a. The applicant or recipient shall have five working days to supply the information or verification requested by the department. The local office may extend the deadline for a reasonable period when the applicant or recipient is making every effort to secure the required information or verification from a third party but has been unable to do so.

b. Failure of the applicant or recipient to supply the information or verification, or refusal by the applicant or recipient to authorize the department to secure the information or verification from other sources, shall serve as a basis for denial of an application or cancellation or reduction of the Medicare drug subsidy.

91.3(3) Interviews. At the discretion of the local office, an interview with the applicant or recipient may be required when processing the initial application or at the time of any review of eligibility.

a. The department shall notify the applicant or recipient in writing of the date, time, and method of any required interview. This notice shall be delivered to the applicant or recipient by personal delivery, mail, or facsimile transmission. Interviews may be rescheduled at the request of the applicant or recipient without written notice.

b. Failure of the applicant or recipient to participate in a scheduled interview shall serve as a basis for denial of an application or cancellation or reduction of the Medicare drug subsidy.

441—91.4(249A) Notice of decision. The department shall notify the applicant or recipient in writing of any decision regarding the applicant's or recipient's subsidy eligibility or level of subsidy.

91.4(1) The department shall issue a written notice of decision to an applicant by the next working day following a determination of subsidy eligibility and level of subsidy.

91.4(2) The department shall give a recipient timely and adequate written notice as provided in rule 441—16.3(17A) when any decision or action is taken that adversely affects subsidy eligibility or the level of subsidy.

91.4(3) In the circumstances described in 441—subrule 16.3(3), the department may dispense with timely notice but shall send adequate notice no later than the effective date of action.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—91.5(249A) Effective date. A Medicare prescription drug subsidy shall be effective beginning with the first day of the month of application or the first day of the first month in which all eligibility requirements are met, whichever is later, but no earlier than January 1, 2006.

441—91.6(249A) Changes in circumstances.

91.6(1) Responsibility to report changes. A Medicare drug subsidy applicant or recipient shall timely report to the department any changes in the following circumstances:

- a.* Care of dependents.
- b.* Household composition.
- c.* Household income.

- d. Household resources.
- e. Marital status.
- f. Medicare eligibility or enrollment.
- g. Place of residence.

91.6(2) *Timely report.* A report shall be considered timely when received in the local office within ten days from the date the change is known to a recipient and within five days from the date the change is known to an applicant.

91.6(3) *Effective date of change.* Changes in eligibility or level of subsidy shall be effective the month following the month in which the change is reported.

441—91.7(249A) Reinvestigation. The department shall reinvestigate eligibility as often as the recipient's circumstances indicate, but in no instance shall the period between reinvestigations exceed 12 months.

91.7(1) *Application requested.* When requested to do so by the department, the recipient shall complete the Medicare drug subsidy application as part of the reinvestigation process. The application shall be completed within five working days from the date a written request is issued. Failure to complete the application shall be a basis for cancellation or reduction of the subsidy.

91.7(2) *Additional information requested.* The recipient shall supply additional information needed to establish eligibility or level of subsidy within five working days from the date a written request is issued.

a. The recipient shall give written permission for the release of information when the recipient is unable to furnish information needed to establish eligibility.

b. Failure to supply requested information or authorize the department to secure the information from other sources shall be a basis for cancellation or reduction of the subsidy.

441—91.8(249A) Appeals. An applicant or recipient shall have the right to appeal any adverse action by the department regarding the Medicare drug subsidy, pursuant to 441—Chapter 7.

These rules are intended to implement Iowa Code sections 217.6 and 249A.4 and Section 1935(a) of the Social Security Act (42 U.S.C. § 1396u-5).

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TITLE IX
WORK INCENTIVE DEMONSTRATION
CHAPTER 93
PROMISE JOBS PROGRAM
[Prior to 7/1/89, see 441—Chapters 55, 59 and 90]

PREAMBLE

This chapter implements the promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program. The PROMISE JOBS program is designed to assist family investment program (FIP) recipients to become self-sufficient. Unless exempt, each FIP applicant must develop a family investment agreement (FIA) that outlines steps the applicant will take to leave public assistance and must cooperate with the terms of the agreement as a condition for receiving FIP as directed in Iowa Code chapter 239B. Rules regarding FIP eligibility requirements, including participation in the PROMISE JOBS program, are found in 441—Chapter 41.

The PROMISE JOBS program also implements the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Title I, “Block Grants for Temporary Assistance for Needy Families (TANF),” which was reauthorized on February 8, 2006, through the Deficit Reduction Act of 2005, Public Law 109-171.

441—93.1(239B) Definitions.

“*Applicant*” means a child for whom assistance is being requested under the family investment program, any parent living in the home with the child, and any nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child.

“*FaDSS*” means the family development and self-sufficiency program operated under 441—Chapter 165, which provides services to families at risk of long-term welfare dependency.

“*Family investment agreement*” or “*FIA*” means the agreement developed with a participant in accordance with Iowa Code section 239B.8.

“*FIA-responsible person*” means any member of the FIP applicant family unless exempt as described at 441—subrule 41.24(2). See subrule 93.4(2) for more information.

“*FIP*” means the family investment program authorized in Iowa Code chapter 239B.

“*Limited benefit plan*” or “*LBP*” means a period of time in which a participant or member of a participant’s family is either ineligible for any assistance under the family investment program or eligible for reduced assistance only in accordance with Iowa Code section 239B.9.

“*Needy specified relative*” means a nonparental specified relative as defined in 441—subrule 41.22(3) who meets all the eligibility requirements to be included in the family investment program.

“*Participant*” for purposes of the PROMISE JOBS program means a person who has signed an FIA and is approved to receive FIP benefits, a parent or relative living in the home of a child approved to receive FIP benefits, or a person reconsidering a subsequent limited benefit plan.

“*PROMISE JOBS program*” means the promoting independence and self-sufficiency through employment, job opportunities, and basic skills program created in Iowa Code section 239B.17.

441—93.2(239B) Program administration. The department of human services shall administer an employment and training program known as PROMISE JOBS. To the extent compatible with resources available, the department’s bureau of refugee services shall provide PROMISE JOBS services to persons who entered the United States with refugee status until those persons obtain United States citizenship.

93.2(1) Availability of service. PROMISE JOBS services shall include, but are not limited to, those listed in paragraph 93.4(4)“b.”

a. The program shall be available statewide. If the department of human services determines that sufficient funds are not available to offer services on location in each county, the department shall prioritize the availability of services to those counties having the largest FIP populations.

b. Because of state and federal budgetary limitations, federal mandatory work requirements, requirements for minimum participation rates, and other TANF requirements imposed on the PROMISE JOBS program, the department of human services shall have the administrative authority to:

- (1) Determine agency and geographical breakdowns for service;
- (2) Designate specific groups for priority services; and
- (3) Designate specific PROMISE JOBS components or supportive service levels for a waiting list.

93.2(2) *Contracts with provider agencies.* The department of human services may contract with the department of workforce development, the department of economic development, or other appropriate entity to provide PROMISE JOBS services and case management of those services.

a. *Reimbursement for services.* The provider agency shall receive financial reimbursement as specified in contracts negotiated with each agency. Contracts shall also specify in detail the expenses that are not eligible for reimbursement.

b. *Record keeping.* All PROMISE JOBS agencies shall maintain PROMISE JOBS participant case files and records for at least three years, in either paper or electronic format. Records shall be maintained for longer than three years if any litigation, audit, or claim is started and not resolved during that period. In these instances, the records must be retained for three years after the litigation, audit, or claim is resolved. Case files must be disposed of in accordance with applicable federal requirements pertaining to confidentiality.

c. *Confidentiality.* The departments of education, workforce development, economic development, and human rights, local education agencies, and all subcontractor provider agencies shall safeguard participant information in conformance with Iowa Code section 217.30. The department of human services and the PROMISE JOBS provider agencies may disclose participant information to other state agencies or to any other entity when that agency or entity must have that information in order to provide services to PROMISE JOBS participants that have been determined to be necessary for successful participation in PROMISE JOBS.

[ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.3(239B) Registration and referral.

93.3(1) *Registration for PROMISE JOBS.* Unless the department of human services determines a person is exempt as specified in 441—subrule 41.24(2), an application for FIP assistance constitutes a registration for the PROMISE JOBS program and acceptance of the requirement to enter into an FIA for all members of the FIP case and all other persons responsible for the FIA as specified at rule 441—41.24(239B).

93.3(2) *Referral.* The department of human services shall refer all FIA-responsible persons from FIP applicant and participant households to PROMISE JOBS pursuant to 441—subrule 41.24(4).

93.3(3) *Initial appointment.*

a. *FIP applicants.* FIP applicants, including those who are in a limited benefit plan, shall be offered an appointment with the PROMISE JOBS provider agency for assessment and FIA development at the earliest available time. The provider agency shall make sufficient appointment times available to allow the applicant to be scheduled no later than ten calendar days after the date of the notice that FIA responsibility has begun, as required by rule 441—93.4(239B) and 441—paragraphs 41.24(1)“c,” 41.24(1)“d,” and 41.24(10)“g.”

b. *Exempt status change.* Persons who become FIA-responsible while receiving FIP shall initiate PROMISE JOBS orientation and FIA development by contacting the appropriate PROMISE JOBS office to schedule an appointment within ten calendar days of the mailing date of the letter explaining that exempt status has been lost and FIA responsibility has begun, as required by 441—subrule 41.24(5). If the person fails to schedule an appointment or fails to appear for an appointment, PROMISE JOBS shall send one written reminder that informs the person that those who do not develop a family investment agreement shall enter into a limited benefit plan. If the person fails to schedule an appointment within

ten calendar days of the reminder letter or fails to appear for an appointment scheduled after the reminder is sent, the person shall enter into a limited benefit plan as described at 441—paragraph 41.24(8) “c.”

93.3(4) Orientation. Every person referred to PROMISE JOBS shall receive orientation services. PROMISE JOBS workers shall provide FIA orientation if not previously provided by the department of human services.

a. During orientation, each applicant shall receive a full explanation of:

- (1) The advantages of employment under the family investment program (FIP), including information on earned income tax credits;
- (2) Services available under PROMISE JOBS;
- (3) Participant rights and responsibilities under the FIA and PROMISE JOBS;
- (4) The limited benefit plan as described at 441—subrule 41.24(8);
- (5) The benefits of cooperation with the child support recovery unit;
- (6) Other programs available through the department of human services, specifically the transitional Medicaid and child care assistance programs; and
- (7) The availability of family planning counseling services in the area and the financial implications of newly born children on the participant’s family.

b. Each applicant shall sign Form 470-3104, Your FIA Rights and Responsibilities, acknowledging that information described in paragraph “a” of this subrule has been provided.

93.3(5) Initial meeting. The PROMISE JOBS worker shall meet with each referred person, or with the family if another parent or a child is also referred to PROMISE JOBS, to:

- a.* Determine participation activities,
- b.* Establish expenses and a schedule for supportive payments, and
- c.* Discuss child care needs.

93.3(6) Workforce development registration. Each applicant is required to complete a current workforce development registration form as described at 877—subrule 8.2(3) when requested by the PROMISE JOBS worker.

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.4(239B) The family investment agreement (FIA). The family investment agreement (FIA) is the condition of and basis for PROMISE JOBS services and is an eligibility requirement for the family investment program as specified in rule 441—41.24(239B).

93.4(1) Development. An initial FIA shall be developed during the orientation and assessment process through discussion between the FIA-responsible person and the PROMISE JOBS worker. For the FIA to be considered completed, Form 470-3095, Family Investment Agreement, and Form 470-3096, FIA Steps to Achieve Self-Sufficiency, shall be signed by all of the following:

- a.* The FIA-responsible person or persons.
- b.* Other family members who are referred to PROMISE JOBS.
- c.* The PROMISE JOBS worker.
- d.* The PROMISE JOBS supervisor.

93.4(2) FIA-responsible persons. All members of the FIP applicant family shall develop and sign an FIA, unless exempt as described at 441—subrule 41.24(2). When an FIA-responsible person is incompetent or incapacitated, someone acting responsibly on that person’s behalf may participate in the interview. Responsibility for carrying out the steps of the FIA ends at the point that FIP assistance is not provided to the participant or when a participant becomes exempt.

a. Parents. All parents who are not exempt from PROMISE JOBS shall be responsible for signing and carrying out the activities of the FIA. Parents of any age are exempt only if they are receiving Supplemental Security Income (SSI) or they do not meet citizenship requirements. When the FIP eligible group includes a minor parent living with one or both parents or a needy specified relative who receives FIP, as described at 441—subparagraph 41.28(2) “b”(2), and none is exempt from PROMISE JOBS participation, each parent or needy specified relative is responsible for a separate FIA.

b. Teens. Persons aged 16 to 19 shall be responsible for signing and carrying out the activities of the FIA unless they are receiving Supplemental Security Income (SSI) or they attend school full-time.

(1) When the FIP-eligible group includes one or both parents or a needy specified relative and a child or children and none is exempt from PROMISE JOBS participation, all shall be asked to sign one FIA with the family and to carry out the activities of that FIA rather than signing separate FIAs. Copies of the FIA shall be placed in each individual case file.

(2) When the FIP-eligible group includes one or both parents or a needy specified relative who is exempt from PROMISE JOBS participation and a child or children who are not exempt, each child is responsible for completing a separate FIA.

(3) A minor nonparental specified relative who is not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

c. Other adults. All other adults who are not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

93.4(3) FIA content. The FIA shall include the goals of the family for achieving self-sufficiency and shall establish a time frame with a specific ending date, during which the family expects to become self-sufficient and after which FIP benefits will be terminated. For individuals and families with acknowledged barriers, one or more incremental FIAs may be written.

a. All FIAs shall:

- (1) Outline the expectations of the PROMISE JOBS program and of the family;
- (2) Clearly establish interim goals and FIA activities necessary to reach long-term goals and self-sufficiency;
- (3) Identify barriers to participation so that the FIA may include a plan, appropriate referrals, and supportive services necessary to eliminate or manage the barriers;
- (4) Stipulate specific services to be provided by the PROMISE JOBS program, including child care assistance, transportation assistance, family development services, and other supportive services;
- (5) Include the participant's responsibility to provide verification of hours of participation, and how and when the verification shall be submitted;
- (6) Record a participant's response to the option of referral for family planning counseling as described at subrule 93.9(3).

b. Plans from other agencies. The FIA may incorporate a self-sufficiency plan that the family has developed with another agency or person, such as, but not limited to, Head Start, public housing authorities, child welfare workers, vocational rehabilitation, and FaDSS grantees, subject to the following requirements:

- (1) The participant shall authorize PROMISE JOBS to obtain the self-sufficiency plan and to arrange coordination with the manager of the self-sufficiency plan by signing Form 470-0429, Consent to Obtain and Release Information.
- (2) The self-sufficiency plan may be included in the participant's FIA if the self-sufficiency plan meets the requirements of this chapter and is deemed by the PROMISE JOBS worker to be appropriate to the family circumstances.

93.4(4) Participation requirements. The FIA shall require the FIA-responsible persons and family members who are referred to PROMISE JOBS to choose participation in one or more activities as described in this subrule.

a. Goals. It is expected that employment leading to economic self-sufficiency is the eventual goal of the FIA.

(1) To the maximum extent possible, the FIA shall reflect the goals of the family, subject to program rules; funding; the capability, experience, and aptitudes of family members; and the potential market for the job skills currently possessed or to be developed.

(2) The program goal for all participants is to be involved in PROMISE JOBS activities on a full-time basis unless barriers prohibit this level of involvement. "Full-time" is considered as an average of at least 30 hours per week. Exceptions to full-time involvement are identified in rule 441—93.14(239B) and subrule 93.4(5).

b. Activities. Except as specified in paragraph 93.4(4) "c," PROMISE JOBS activities may include, but are not limited to, any combination of the following activities:

- (1) Orientation as described in subrule 93.3(4).

- (2) Assessment as described in rule 441—93.5(239B).
- (3) Job readiness activities, including job club, individual job search, workplace essentials training, mental health treatment, substance abuse treatment, or other rehabilitative activities, as described in rule 441—93.6(239B).
- (4) Work activities, including part-time or full-time employment, self-employment, on-the-job training, work experience, or unpaid community service as described in rule 441—93.7(239B).
- (5) Educational activities, including high school completion, high school equivalency diploma (HSED) certification, adult basic education (ABE), English as a second language (ESL) training, vocational training, or postsecondary training up to and including a baccalaureate degree, as described in rule 441—93.8(239B).
- (6) Parenting skills training as described in subrule 93.9(1).
- (7) Participation in the family development and self-sufficiency program (FaDSS) or other family development programs as described in subrule 93.9(2).
- (8) Referral for family planning counseling as described in subrule 93.9(3).
- (9) Services provided by other agencies.

c. FIA activities for participants aged 16 to 19. Development of FIA activities shall follow these guidelines for participants aged 16 to 19.

(1) Participants aged 16 to 19 who are not parents and who have not completed high school shall be strongly encouraged to participate in educational activities to obtain a high school diploma or the equivalent. A high school education is recognized as important to achieving self-sufficiency. Participants shall be given information on the earning power of people with a high school education compared to those who do not so that participants are able to make an informed choice. If high school or high school equivalency completion is not included in a teenager's FIA, other FIA activities shall be required. High school or high school equivalency completion shall be proposed and reconsidered at the next FIA review.

(2) Parents under the age of 18 who are not married and who have not completed high school shall be expected to use enrollment or continued attendance in high school or involvement in a high school equivalency program as a first step in the FIA, except when the parent is deemed incapable of participating in these activities by the local education agency.

(3) Parents aged 19 and younger shall include parenting skills training as described at subrule 93.9(1) in their FIA or the case file shall include documentation that this requirement has been fulfilled.

(4) Unmarried parents aged 17 and younger who do not live with a parent or legal guardian shall include FaDSS, as described at 441—Chapter 165, or other family development services, as described in subrule 93.9(2), in the FIA. The FaDSS or other family development services shall continue after the parent reaches the age of 18 only when the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

d. Waiting lists. The department of human services reserves the authority to prioritize services to FIP applicants and participants in the order that best fits the needs of FIP applicants and recipients and of the PROMISE JOBS program. Participants who are placed on a waiting list for a PROMISE JOBS component shall include other appropriate activities in the FIA while waiting unless family circumstances indicate otherwise.

(1) Persons shall be removed from these waiting lists and placed in components at the discretion of state-level PROMISE JOBS administrators in order to help participants achieve self-sufficiency in the shortest possible time, meet budgetary limitations, enable participants to make maximum use of other programs, fulfill the federal minimum participation rate requirements, and meet other TANF requirements.

(2) Persons who were enrolled in approved postsecondary training at the time of FIP cancellation shall not be placed on a postsecondary training waiting list if the participant is still satisfactorily participating in approvable training at the time that FIP eligibility is regained.

e. Unavailability of funding. If funding for the PROMISE JOBS activities included in a participant's FIA or required supportive payments are not available, the participant's FIA shall be renegotiated to include different activities.

93.4(5) Barriers to participation. Problems with participation of a permanent or long-term nature shall be considered barriers to participation and shall be identified in the FIA as issues to be resolved or managed so that maximum participation can result.

a. Barriers defined. Barriers to participation shall include, but not be limited to, the following:

(1) Child or adult care needed before a person can participate or take a job is not available. Participants are not required to do any activity unless suitable child or adult care has been arranged.

(2) Lack of transportation.

(3) Substance addiction.

(4) Sexual or domestic abuse history.

(5) Overwhelming family stress.

(6) Physical or cognitive disability or mental illness.

b. Inclusion in FIA.

(1) When barriers are identified during assessment, removal or management of the barrier shall be part of the FIA from the beginning.

(2) When barriers are revealed by the applicant or participant during the FIA development or are identified by problems that develop after the FIA is signed, the FIA shall be renegotiated and amended to provide for removal or management of the barriers.

(3) In limited instances where special-needs care for a child or adult is not available, it may be most practical for the participant to develop the FIA to identify providing the care as part of the FIA.

c. Cooperation with removing or managing barriers.

(1) Applicants. An FIA-responsible applicant who chooses not to cooperate in removing or managing barriers to participation identified during FIA development shall be denied FIP.

(2) Participants. A participant who chooses not to cooperate in removing or managing identified barriers to participation shall be considered to have chosen the limited benefit plan. If the participant claims a cognitive or physical disability or mental illness that is expected to last for more than 12 consecutive months, the participant is required to apply for Social Security Disability and Supplemental Security Income benefits. When the participant refuses to apply for those benefits, the FIP household is ineligible for FIP as described at 441—subrule 41.27(1), and the limited benefit plan does not apply.

93.4(6) Failure to complete an FIA.

a. FIP applicants. An applicant's failure to develop or sign an FIA shall result in denial of the family's application for FIP assistance, as described at 441—paragraphs 41.24(4) "a," "b" and "c."

b. FIP participants. FIP participants who choose not to enter into an FIA or who choose not to continue its activities after signing an FIA shall enter into the limited benefit plan (LBP) as described at 441—subrule 41.24(8).

93.4(7) Progress reviews. The PROMISE JOBS worker shall review all FIAs at least once every six months. Progress reviews do not have to be face-to-face interviews but must include verbal contact with and input from at least one family member. FIA goals, Form 470-3096, FIA Steps for Achieving Self-Sufficiency, and, if appropriate, the needs for child care, transportation, and other supports shall be reviewed for continued appropriateness.

93.4(8) Renegotiation.

a. The FIA shall be renegotiated to reflect a new plan for self-sufficiency if:

(1) The participant has participated satisfactorily in the current FIA activities but is not self-sufficient by the end date specified in the FIA; or

(2) The participant demonstrates effort in carrying out the steps of the FIA but is unable to participate satisfactorily in the current FIA activities due to a barrier as described at subrule 93.4(5); or

(3) The participant's circumstances change to such an extent that the current FIA activities are no longer appropriate.

b. Participants who choose not to cooperate in the renegotiation process when requested by PROMISE JOBS shall be considered to have chosen the limited benefit plan.

93.4(9) Reinstatement. When a participant who has signed an FIA loses FIP eligibility and has not become exempt from PROMISE JOBS at the time of FIP reapplication, the contents of the original FIA and the participant's responsibility for carrying out the steps of that FIA may be reinstated when the steps

of the FIA fit the family's current circumstances. The FIA shall be renegotiated and amended if needed to accommodate changed family circumstances.

[ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.5(239B) Assessment. The purpose of assessment is to provide an evaluation of the FIP applicant or participant family that furnishes a basis for the PROMISE JOBS worker to determine: (1) family members' employability and educational potential, so that participants can make well-informed choices; and (2) the services that will be needed for the family to achieve self-sufficiency, so that the worker can provide appropriate guidance.

93.5(1) Initial assessment. All persons referred to PROMISE JOBS shall complete an initial assessment, which shall be used to develop the initial FIA. The PROMISE JOBS worker shall meet individually with FIA-responsible persons who are referred to PROMISE JOBS to develop the FIA.

a. Self-assessment. The participant may either fill out Form 470-0806, Self-Assessment, before the meeting or fill the form out during the meeting with assistance from the PROMISE JOBS worker. The results from self-assessment shall be used to assist in identifying the applicant's needs.

b. Scope of initial assessment. The initial assessment meeting, at a minimum, shall review the family's financial situation, family profile and goals, employment background, educational background, housing needs, child care needs, transportation needs, health care needs, family-size assessment and the participant's wishes regarding referral to family planning counseling, and other barriers which may require referral to entities other than PROMISE JOBS for services.

93.5(2) Additional assessments. Additional assessments may include, but are not limited to, literacy and aptitude testing, educational level and basic skills assessment, evaluation of job interests or job skills, occupation-specific assessment or testing, or an evaluation of past pertinent information. An additional assessment may be used by mutual agreement between the PROMISE JOBS worker and the participant as a tool and to help explore possible FIA development. For a specific additional assessment to be required, completion of the assessment must be specified in the FIA.

a. Additional information on applicants. If information identified during the initial assessment indicates that further information is needed to help the participant and PROMISE JOBS worker identify appropriate FIA activities and level of involvement, the applicant shall complete additional assessments as determined by the PROMISE JOBS worker. Completion of this assessment may be the first step in the initial FIA.

b. Medical examination. The PROMISE JOBS worker may require a person to complete a medical examination before including a particular PROMISE JOBS activity in the FIA when a participant specifies or exhibits any condition that might jeopardize successful participation in the program. The worker shall ask the health practitioner to indicate to the best of the practitioner's knowledge whether the person is capable of completing the FIA activity or continuing with appropriate employment.

c. Rehabilitation assessments. At any time during the assessment process or as more information is revealed, a referral may be made for professional assessments in physical health, mental health, substance abuse, or other rehabilitative services.

d. Additional information on participants. Assessments may be completed or redone at any time throughout the development and duration of the FIA if the information is needed to help the participant and the PROMISE JOBS worker make decisions concerning the type or level of the participant's involvement in PROMISE JOBS activities.

93.5(3) Postsecondary educational evaluation. Participants who wish to include postsecondary education in their FIA shall complete an educational evaluation to determine the likelihood of success.

a. Request for education resulting in a vocational certificate or certificate of completion. Vocational certificate or certification of completion training programs offer short-term training in a specific vocational area. Examples include, but are not limited to: nurse aid certification, training to receive a commercial driver's license, training in information technology, health care services, and child care services. The PROMISE JOBS worker shall determine the likelihood of success using the following types of tools or information:

- (1) A review of information from past training situations,
- (2) Past job performance in comparable positions,
- (3) Basic skills tests,
- (4) Career-specific assessments,
- (5) A specific standardized test, or
- (6) Other key historical information.

b. Request for education resulting in an associate or baccalaureate degree. The PROMISE JOBS worker shall determine the likelihood of academic success through an educational evaluation. The evaluation may include use of the following types of tools or information:

- (1) Standardized assessments in reading comprehension, math, and writing skills, such as GATB (General Aptitude Test Battery), Kuder Skills Assessment, or CASA (Comprehensive Adult Student Assessment) system;
- (2) Occupation-specific skills assessments;
- (3) Interest inventories;
- (4) Current or past grades; and
- (5) Other pertinent historical information.

c. Documenting educational evaluation results. When a participant has requested education to be included in the FIA, the PROMISE JOBS worker shall document:

- (1) What formal assessments were completed, if any, and what the results were;
- (2) What other information was reviewed;
- (3) How the evaluation information was used by the PROMISE JOBS worker in either approving or denying the inclusion of education in the participant's FIA; and
- (4) Whether the request is approved or denied. If the request is denied, PROMISE JOBS shall issue Form 470-0602, Notice of Decision: Services, to the participant as required in paragraph 93.10(1) "b."

93.5(4) Substituting or supplementing an assessment.

a. Substituting assessment information. If the FIA-responsible person's mental status, physical status, and life situation have not changed significantly, comparable assessment information completed with another agency or person within the past two years may be used instead of performing new assessments.

(1) Examples of agencies or persons that may complete comparable assessment information include, but are not limited to, the department of workforce development, Head Start, public housing authorities, child welfare workers, vocational rehabilitation services, an educational institution or testing service, or family development services.

(2) The FIA-responsible person may authorize PROMISE JOBS to obtain these assessment results by signing Form 470-0429, Consent to Obtain and Release Information.

b. Supplementing assessment information. In order to ensure that the family investment agreement activities do not conflict with any case plans that have already been established for the family, the FIA-responsible person may:

- (1) Supplement assessment information, and
- (2) Establish communication between the PROMISE JOBS worker and other agencies or persons.

c. Use of key historical information. When key historical information, such as a review of the participant's job history or past training outcomes, relays a clear picture of the participant's skills and abilities, a formal, standardized educational assessment may not be needed.

(1) If a participant is currently enrolled in or has been enrolled in comparable training or an academic program in the past two years, the evaluation of the participant's performance, including grades received, may be substituted for a formal, standardized educational assessment.

(2) When using historical information as an indicator of future success, changes in the participant's mental status, physical status, life circumstances, and motivation shall be given consideration.

93.5(5) Assessment after FIP cancellation or limited benefit plan. FIP participants who previously participated in either a basic or additional assessment and then were canceled from FIP or entered a limited benefit plan may be required to complete an assessment again when the PROMISE JOBS worker determines that updated information is needed for development or amendment of the FIA.

93.5(6) *Participants with FaDSS services only.* For participants with FaDSS services as the only activity in their FIA, the PROMISE JOBS worker shall use information provided by the FaDSS worker to help assess when a participant is ready to participate in other PROMISE JOBS activities. The PROMISE JOBS worker may require additional assessments to be completed if more information is needed to decide the type or level of the participant's involvement in other PROMISE JOBS activities.

93.5(7) *Documenting participation.* The participant shall provide documentation of participation in assessments as described at subrule 93.10(2). Persons who miss any portion of a scheduled assessment may be required to make up the missed portion, based on worker judgment and participant needs.

93.5(8) *Supportive payments allowed.* Except for assessment activities that occur on the same day as orientation, persons participating in assessment activities are eligible for payments for transportation and child care needed to allow the scheduled participation as described at rule 441—93.11(239B). When make-up sessions are required, the participant shall not receive an additional transportation payment, but necessary child care shall be paid.

93.5(9) *Failure to complete assessment.* Participants who do not complete assessments that are written into their FIA shall be considered to have chosen the limited benefit plan unless they have good cause. Procedures at 441—93.14(239B) shall apply.

441—93.6(239B) *Job readiness and job search activities.* Job readiness and job search activities include job club, job search, workplace essentials training, substance abuse treatment, mental health treatment, and other rehabilitation activities. The participant and the PROMISE JOBS worker shall incorporate into the FIA the job readiness and job search activities that are appropriate for the goals, work history, skill level, and life circumstances of the participant.

93.6(1) *Job club.* Job club prepares participants to search for work. Job club consists of training in job-seeking skills and structured job search.

a. Delivery of services. Job club is provided over a consecutive three-week period. Each week consists of 30 hours of structured activity.

(1) Generally, the first week of job club consists of job-seeking skills training and the next two weeks consist of structured group job search.

(2) Based on local office need and resources, the 30 hours of job-seeking skills training may be completed over the first two weeks when the hours not spent in job-seeking skills training are spent in structured job search. The total time spent in each of the two weeks must meet the 30-hour requirement. The third week of job club is 30 hours of structured group job search.

b. Job-seeking skills training. Job-seeking skills training may include but is not limited to:

- (1) Résumé development;
- (2) Writing application and follow-up letters;
- (3) Completing job applications and interest and skills assessments;
- (4) Job retention skills;
- (5) Motivational exercises;
- (6) Identifying and eliminating employment barriers;
- (7) Self-marketing;
- (8) Finding job leads;
- (9) Obtaining interviews;
- (10) Use of telephones for job seeking;
- (11) Interviewing skills; and
- (12) Financial education.

c. Structured job search. A written plan shall be developed with each participant using Form 470-4481, Job Search Plan Agreement, indicating the number of job search hours required depending on family circumstances and other component activities listed on the participant's FIA. Structured job search includes daily reporting to the job search site to access resources for job leads.

d. Attendance. Daily attendance is required during both the job-seeking skills training and structured job search. Participants who miss any portion of the job-seeking skills training or structured

job search may be required to either make up the missed portion of the sessions or to retake the entire week of training based on practical worker judgment and participant need.

(1) Participants who obtain employment are required to continue the job-seeking skills training unless the scheduled job club hours conflict with the scheduled hours of employment.

(2) Participants who obtain employment averaging 30 hours or more per week may discontinue the structured job search portion of job club.

(3) Participants who obtain employment averaging 20 hours per week or more but less than 30 hours per week may discontinue the structured job search portion of job club if part-time employment was the FIA goal or the scheduled job club hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with work hours.

(4) Participants who obtain employment averaging less than 20 hours per week shall continue the structured job search portion of job club unless the scheduled job club hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with work hours.

e. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed to participate in job club. The transportation payment shall be paid in full at the start of participation.

(1) Participants who must repeat the job-seeking skills training or structured job search because of absence due to reasons as described at rule 441—93.14(239B) shall receive an additional transportation payment as described at subrule 93.11(3) for each day that must be repeated and a child care payment for needed child care. This rule applies only when the participant will have transportation costs that exceed the participant's original payment because of repeating a portion of job club.

(2) Participants who must repeat job-seeking skills training or structured job search as a result of absences due to reasons other than those described at rule 441—93.14(239B) shall not receive an additional transportation payment.

f. Documenting job club participation. Participants shall provide documentation of job search activities as described at subrule 93.10(2).

g. Failure to participate in job club activities. Participants who without good cause do not appear for scheduled job club activities or who fail to complete or document and submit job search contacts according to their written plan shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(2) Individual job search. Individual job search shall be available to all participants, particularly those who have recent ties with the workforce, have successfully removed or reduced barriers to work, or have completed job club or training and are now ready to work. If after three calendar months the participant still has not found employment, the worker shall review the participant's situation for possible barriers to employment or possible need for training to increase the participant's employability. Job search may continue if appropriate, but linking with other activities should be considered.

a. Job search plan. In consultation with the PROMISE JOBS worker, the participant shall design and provide a written plan of the individual job search activities on Form 470-4481, Job Search Plan Agreement. The plan shall:

(1) Contain a designated period for job search not to exceed five weeks ending on a Friday within the same calendar month and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for each week of the designated period so as to provide the most effective use of transportation funds.

(3) Specify due dates for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interest, employers to be contacted, and other pertinent factors.

b. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed for participation in individual job search. The transportation payment shall be paid in full at the start of each designated period of the individual

job search. Transportation payments for any missed days of job search activity shall be subject to transportation overpayment policies as described at subrule 93.11(3).

c. Documenting job search participation. The participant shall document the actual hours spent on job contacts and other job search activities. Participant documentation shall be provided as described at subrule 93.10(2).

d. Failure to participate in individual job search. Participants who without good cause do not complete the steps of the written plan of the individual job search shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(3) Unplanned job opportunity. PROMISE JOBS participants who have an unplanned opportunity to interview or apply for a job shall be encouraged to take advantage of the opportunity.

a. Supportive payments allowed. Child care and transportation payments needed to make an unplanned job contact shall be provided as described at rule 441—93.11(239B) when the following conditions are met:

- (1) The participant has a signed FIA,
- (2) The job contact is an in-person contact to complete an application or to attend an interview, and
- (3) The participant provides documentation as described in paragraph “b” of this subrule. Payment shall be issued after documentation is received.

b. Documenting participation. The participant shall provide documentation of the actual time spent making the specific job contact. Documentation shall be provided as described at subrule 93.10(2).

c. Limited benefit plan. A limited benefit plan does not apply when a participant fails to complete a job contact that is not part of a structured or individual job search plan.

93.6(4) Workplace essentials. The workplace essentials component consists of soft skills and life-skills training.

a. Delivery of services. Workplace essentials training is one 30-hour week in duration. Based on local office need and resources, the 30 hours may be completed over a two-week period. For the remainder of the 30 participation hours required in each week, participants must engage in other PROMISE JOBS activities.

b. Content. Workplace essentials training may include but is not limited to:

- (1) Identifying and setting goals.
- (2) Self-esteem building.
- (3) Emotional awareness.
- (4) Relationship management.
- (5) Conflict-resolution skills.
- (6) Problem-solving skills.
- (7) Decision-making skills.
- (8) Time-management skills.
- (9) Team-building skills.
- (10) Networking skills.
- (11) Listening skills.
- (12) Positive thinking.
- (13) Priority setting.
- (14) Appropriate workplace behaviors.
- (15) Cultural sensitivity.
- (16) Workplace expectations.
- (17) Stress management.

c. Supportive payments allowed. Child care and transportation payments shall be provided as described at rule 441—93.11(239B) when needed to participate in workplace essentials.

d. Documenting participation. The PROMISE JOBS worker shall verify and document each participant’s monthly hours of actual participation in workplace essentials. Participant documentation shall be provided as described at subrule 93.10(2).

e. Failure to participate in workplace essentials. Participants who without good cause do not complete workplace essentials as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.6(5) Substance abuse treatment, mental health treatment, and other rehabilitative activities. Substance abuse or mental health treatment or other rehabilitative activities are available when needed for a participant to be successful in participating in other FIA activities.

a. Treatment determination. The need for treatment or rehabilitative activities must be determined by a qualified medical professional, substance abuse professional, or mental health professional. The qualified professional must document that treatment or rehabilitative activities are needed for the participant to obtain or retain employment.

b. Supportive payments allowed. Transportation and child care payments as described at rule 441—93.11(239B) are available for participating in substance abuse treatment, mental health treatment, or other rehabilitative activities when specified in the FIA.

c. Documenting participation. The service provider shall verify actual hours of participation in treatment. Documentation of participation shall be provided as described at subrule 93.10(2).

d. Failure to participate in treatment or other rehabilitative activities. Participants who without good cause do not participate in substance abuse treatment, mental health treatment, or other rehabilitative activities as specified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.7(239B) Work activities. Work activities include full-time employment, part-time employment, self-employment, on-the-job training, work experience placement, and unpaid community service. The participant and the PROMISE JOBS worker shall incorporate into the FIA employment activities that are appropriate for the work history, skill level, and life circumstances of the participant. If the FIA activity is so hazardous that safety glasses, hard hats, or other safety equipment is needed, participation shall not be arranged or approved unless these safety precautions are available.

93.7(1) Full-time or part-time employment. FIAs may include full-time employment or part-time employment. Employment that does not lead to economic self-sufficiency may be included in the FIA only if the employment situation leads to better employment opportunities through building work skills and work history. See subrule 93.7(2) for additional policies applicable to self-employment.

a. Full-time employment. The goal for all participants is to participate in full-time employment. “Full-time employment” is defined as being employed an average of 30 or more hours per week.

(1) Persons who have not achieved self-sufficiency through full-time employment before the end date of the FIA may have the FIA extended.

(2) Persons who choose not to enter into the renegotiation process to extend the FIA shall be considered to have chosen the limited benefit plan.

b. Part-time employment. Part-time employment is defined as being employed an average of less than 30 hours per week. An FIA that includes part-time employment shall also include participation in other PROMISE JOBS activities, including additional part-time employment, unless barriers to participation exist as defined in rule 441—93.14(239B) and subrule 93.4(5).

c. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at rule 441—93.11(239B).

d. Verification of employment hours. Participants must provide verification of employment hours as described at subrule 93.10(2).

e. Failure to provide verification. Failure to provide verification of work hours after receiving a written reminder will result in a limited benefit plan.

f. Failure to maintain employment. A participant who without good cause does not maintain employment as identified in the FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(2) Self-employment.

a. Calculation of hours. Hours of participation for persons who are self-employed shall be calculated using actual gross income less business expenses divided by the federal minimum wage. PROMISE JOBS shall use the same income as used for FIP eligibility and benefits.

(1) Participants with self-employment income that equates to 30 or more hours per week are considered to be working full-time.

(2) Participants with self-employment income that equates to less than 30 hours per week are considered to be working part-time.

b. Review of participation. The PROMISE JOBS worker shall review calculated hours:

(1) When income changes, or

(2) At least once every six months.

c. Progress toward self-sufficiency. At the participant's FIA review, the participant's progress is determined by noting incremental increases in income and calculated work hours. In order to maintain self-employment as the only FIA activity, participants must:

(1) Reach full-time employment as defined in subparagraph 93.7(2) "a"(1), or

(2) Show progress toward self-sufficiency.

d. Requiring other FIA activities. When a participant has been self-employed for more than 12 months and has not shown progress toward self-sufficiency, the FIA shall include the part-time self-employment in combination with participation in other PROMISE JOBS activities, unless barriers to participation exist as described in subrule 93.4(5).

(1) The other activities could include additional part-time employment.

(2) When the determination that a participant has not shown progress toward self-sufficiency is made after the initial FIA is developed, the FIA shall be renegotiated to include the other PROMISE JOBS activities. Participants who choose not to enter into the FIA renegotiation process shall enter into a limited benefit plan as described in 441—subrule 41.24(8).

e. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at subrule 93.11(2).

f. Documenting participation. Hours of participation in self-employment shall be calculated as specified in paragraph 93.7(2) "a" and documented in the case file. Participant documentation shall be provided as described at subrule 93.10(2).

g. Failure to maintain employment. Participants who without good cause do not maintain employment as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(3) On-the-job training.

a. Definition. "On-the-job training" is defined as training in the public or private sector that:

(1) Is given to a paid employee while the employee is engaged in productive work, and

(2) Provides knowledge and skills essential to the full and adequate performance of the job.

b. Supportive payments. Transportation for on-the-job training is treated in the same manner as transportation for employment. Expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care payments shall be provided when needed as described at subrule 93.11(2).

c. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

d. Failure to participate in on-the-job training. Participants who without good cause do not participate in on-the-job training as identified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at 441—93.14(239B) shall apply.

93.7(4) Work experience program. Work experience sites shall provide participants with work experience and on-the-job training opportunities.

a. Sponsors. Employers who participate in the work experience program are referred to as sponsors. Work experience sponsors may be public sector, private sector, community-based, faith-based, or nonprofit employers.

(1) Participants may be placed at work sites with religious institutions only when the work performed is nonsectarian and not in support of sectarian activities.

(2) Participants may not be used to replace regular employees in the performance of nonsectarian work for the purpose of enabling regular employees to engage in sectarian activities.

(3) Each work experience program sponsor shall provide to the PROMISE JOBS service provider a copy of the sponsor's safety rules before participants are referred for work site placement.

b. Positions. To request a work experience placement, the sponsor shall complete Form 470-0809, Sponsor's Request for Work Experience (WEP) Participant, for each type of position the sponsor wishes to fill. The request shall include a complete job description that specifies all tasks to be performed by the participant. PROMISE JOBS has final authority to determine suitability of any work experience position offered by a sponsor. Work experience positions:

(1) Must contain the same job description and performance requirements that would exist if the sponsor were hiring an employee for the same position;

(2) Shall not be related to political, electoral, or partisan activities;

(3) Shall not be developed in response to or in any way be associated with the existence of a strike, lockout, or other bona fide labor dispute;

(4) Shall not violate any existing labor agreement between employees and employers;

(5) Shall comply with applicable state and federal health and safety standards;

(6) Shall not be used by sponsors to displace current employees or to infringe on the promotional opportunities of current employees;

(7) Shall not be used in place of hiring staff for established vacant positions; and

(8) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

c. Participant selection. A participant's vocational skills and interests shall be matched as closely as possible with the job description and skills required by the sponsor.

(1) Participant responsibility. Participants shall interview for and accept positions offered by work experience sponsors. Participants shall present Form 470-0810, Referral for Work Experience (WEP) Placement, to the sponsor at the interview. The form shall be completed by the sponsor and returned to PROMISE JOBS.

(2) Sponsor responsibility. Although sponsors are expected to accept work experience referrals made by PROMISE JOBS, sponsors may refuse any referrals they deem inappropriate for the available position. Sponsors shall not discriminate against any program participant because of race, color, religion, sex, age, creed, physical or mental disability, political affiliation, or national origin. Sponsors who refuse a referral must notify PROMISE JOBS in writing of the reason for the refusal.

d. Hours of participation. When a participant is involved in work experience that is subject to the Fair Labor Standards Act (FLSA), the participant cannot be required to work more hours than the amount of the monthly FIP grant divided by federal or state minimum wage, whichever is higher. EXCEPTION: To determine the maximum hours that can be required of a single-parent family on FIP with a child under the age of six, add the value of the family's food assistance to the FIP grant amount before dividing by the minimum wage.

(1) A participant cannot be required to work more hours than those calculated under paragraph "d" of this subrule. Only hours up to or less than that calculation can be included in the participant's FIA.

(2) If two or more members of the same household participate in work experience, the total required hours of participation of the household cannot exceed the hours calculated according to paragraph "d" of this subrule.

(3) Each work experience assignment shall not exceed six months in duration.

e. Participant performance evaluations.

(1) Monthly evaluations. Sponsors shall complete a monthly evaluation of the participant's performance using Form 470-0805, Work Experience Participant Evaluation, and provide a copy to PROMISE JOBS and to the participant.

(2) Final evaluations. Sponsors shall complete Form 470-0805, Work Experience Participant Evaluation, at the time of termination for each work experience participant. When termination occurs

at the sponsor's request, the sponsor shall specify the reason for termination and identify those areas of unsatisfactory performance. For participants who leave to accept regular employment or reach their work experience placement time limit, the sponsor's evaluation shall indicate whether or not a positive job reference would be provided if the participant requested one.

f. Supportive payments for work experience placements.

(1) Child care and transportation. Participants assigned to work experience shall receive a child care payment, if required, and a transportation payment for each month or part thereof as described at subrules 93.11(2) and 93.11(3). The portion of the transportation payment for job-seeking activities shall be determined by including the day of the job search obligation in the normally scheduled days used in the formulas described at subrule 93.11(3).

(2) Required clothing and equipment. A participant may receive up to a limit of \$100 per work-site assignment for clothing or equipment if required by the work experience site and not covered by the sponsor.

(3) Workers' compensation. The department of human services shall provide workers' compensation coverage for all PROMISE JOBS work experience participants.

g. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

h. Completion of work experience. Persons who complete a work experience assignment may move to another activity as provided under the FIA, be assigned to a different work site, or be reassigned to the same work site, whichever is appropriate under the FIA.

i. Failure to participate in work experience. A participant who without good cause does not participate in work experience as identified in the FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.7(5) Unpaid community service. Unpaid community service shall provide participants with opportunities to establish or reestablish contact with the workforce while providing services that are of direct benefit to the community.

a. Work sites. Unpaid community service work sites shall be public or private nonprofit organizations. The PROMISE JOBS provider agencies shall provide community service work sites a written explanation of the following placement criteria. The placement:

- (1) Shall comply with applicable state and federal health and safety standards;
- (2) Shall not be related to political, electoral or partisan activities;
- (3) Shall not be developed in response to or in any way associated with the existence of a strike, lockout, or other bona fide labor dispute;
- (4) Shall not violate any existing labor agreement between employees and employers;
- (5) Shall not be used to displace current employees or to infringe on their promotional opportunities;
- (6) Shall not be used in place of hiring staff for established vacant positions; and
- (7) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

b. Locating the work site. The PROMISE JOBS provider agencies shall develop local listings of potential unpaid community service work sites. When a participant and the PROMISE JOBS worker agree that an unpaid community service placement is appropriate, the participant is responsible for locating and making arrangements with the work site. Formal interviews are not required to establish the relationship between the participant and the work site organization.

c. Length of assignment and weekly hours. The length of the work site assignment and the weekly hours of participation shall be determined through agreement among the work-site organization, the participant, and the PROMISE JOBS worker. When a participant is involved in community service that is subject to the Fair Labor Standards Act (FLSA), the participant cannot be required to work more hours than the amount of the participant's monthly FIP grant divided by federal or state minimum wage, whichever is higher. Only hours up to or less than the maximum calculated may be included in the participant's FIA. Exceptions are as follows:

(1) For a participant who is a single parent with a child under the age of six, the maximum hours that can be required are determined by adding the value of the participant's food assistance to the FIP grant amount before dividing by the minimum wage.

(2) Participants who are court-ordered to do community service shall work the number of hours required by the court.

e. Supportive payments. A child care payment and a transportation payment for each month of participation or part thereof shall be paid as described at rule 441—93.11(239B) if these services are required for participation.

f. Documenting participation. Documentation of participation shall be provided as described at subrule 93.10(2).

g. Failure to complete unpaid community service. Participants who without good cause do not participate in unpaid community service as specified in their FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

[ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.8(239B) Education and training activities. Education refers to any academic or vocational course of study that enables a participant to complete high school, improves a participant's ability to read and speak English, or prepares a participant for a specific professional or vocational area of employment. Though employment leading to economic self-sufficiency is the eventual goal of all FIAs, it is recognized that education increases a person's chance of finding employment, particularly employment that leads to economic self-sufficiency. Any participant who requests participation in educational activities shall be evaluated to determine the likelihood of success. If the request is approved, a training plan shall be developed and included in the participant's FIA.

93.8(1) Participant requirements. The decision to include education in an FIA shall take into account the results of the educational evaluation pursuant to paragraph "b" of this subrule and the current educational level of the participant. Prior academic or vocational training is not, in itself, a reason for denial or approval of educational services. All family members who are approved for education shall be eligible for all program benefits, even when two or more family members are simultaneously participating and even if participation is at the same educational facility and in the same program. For education to be approved for inclusion in an FIA, the following requirements shall be met.

a. Vocational goal. For a participant enrolled in postsecondary education, the education must lead to a specific vocational goal. A degree in general studies or programs not leading to specific occupational outcomes cannot be included in a participant's FIA.

(1) Except as provided in subparagraph 93.8(1) "a"(2), a vocational goal must be in an occupational field for which available labor market information or emerging business trends in the participant's local area indicate employment potential. These trends or statistics must be provided by a legitimate source, such as but not limited to:

1. The department of workforce development,
2. Private employment agencies, or
3. Local employers providing jobs paying at least minimum wage for which the education is being requested.

(2) Information to support employment potential in the participant's local area is not required when:

1. The participant has a documented job offer in the field before entering the training; or
2. The participant is willing to relocate after training to an area where there is employment potential. Documentation for the new location shall meet the requirements in subparagraph 93.8(1) "a"(1).

(3) For participants attending high school or high school equivalency activities, adult basic education or English as a second language, the vocational goal is to improve employability by successfully completing the activity.

b. Evaluation. A participant under the age of 19 does not need to complete an educational evaluation in order to have high school completion included in the FIA. For every other training activity,

an educational evaluation shall be completed according to this paragraph before the activity is included as part of a participant's FIA.

(1) A participant who chooses to enter educational activities before obtaining approval is not eligible to receive supports as described in subrule 93.8(6), cannot use that activity to meet the FIA participation obligation, and shall be expected to participate in other FIA activities.

(2) A participant who is already involved in education at the time of FIP application or enters education before approval must meet the requirements in this rule before the educational activities can be included in the FIA. Once approved, the current educational activity may then be included in the participant's FIA, and the participant will be eligible to receive supports as described in subrule 93.8(6).

93.8(2) Provider requirements. Both public and private agencies may provide educational activities.

a. Type of provider. Education may be included in the FIA if obtained from a provider that is approved or registered with the state or is accredited by an appropriate accrediting agency. Training provided by a community action program, church, or other agency may be included in the FIA only if the PROMISE JOBS worker determines that:

(1) The training is adequate and leads to the completion of the participant's vocational goal; and

(2) The training provider possesses appropriate and up-to-date equipment; has qualified instructors, adequate facilities, a complete curriculum, acceptable grade point requirements, and a good job-placement history; and demonstrates expenses of training that are reasonable and comparable to the costs of similar programs.

b. Time and attendance. The participant's actual hours attending an educational activity must be verified pursuant to subrule 93.10(2). If the educational activity is structured in such a way that verification cannot be obtained or the educational provider is unwilling to provide time and attendance verification, the educational activity cannot be included in the participant's FIA.

93.8(3) Approvable activities. Training plans shall include only training activities that can be considered as meeting the FIA obligations for participation. The following activities may be included in a training plan:

a. Adult basic education.

b. Continuing education units when needed for the participant to be recertified or retrained to reenter a field in which the participant was previously trained or employed or to maintain certification needed to remain employed.

c. Correspondence courses when the courses are required but not offered by an educational facility attended by the participant.

d. English as a second language.

e. High school or high school equivalency completion. Any participant who does not have a high school diploma or high school equivalency diploma (HSED) shall be encouraged to obtain a diploma. A participant who is 18 years of age or older may be approved to return to regular high school only when the participant can graduate within one year of the normal graduation date. High school equivalency or high school courses and other types of vocational training may run concurrently.

f. On-line or distance learning. Distance learning includes training such as, but not limited to, that conducted over the Iowa communications network, on-line courses, or Web conferencing. The training:

(1) Must include interaction between the instructor and the student, such as required chats or message boards;

(2) Must include mechanisms for evaluation and measurement of student achievement; and

(3) Must be offered in Iowa unless the conditions in paragraph "g" of this subrule apply. An on-line training program shall be considered an out-of-state training program when any of the required training or testing occurs out-of-state.

g. Out-of-state training. Out-of-state training is approvable only when:

(1) Similar training is not available in Iowa,

(2) Relocation required to attend an in-state facility would be unnecessary if attending an out-of-state facility, or

(3) The only in-state facilities within commuting distance are private schools where tuition costs are higher than at an out-of-state facility within commuting distance.

h. Postsecondary education up to and including a baccalaureate degree program.

(1) A participant with no postsecondary education may be approved for training resulting in a certificate of program completion or an academic degree, such as an associate or baccalaureate degree. Participants who have not completed a high school education or received a high school equivalency diploma (HSED) may be required to do so before courses leading to an associate degree or higher are approved.

(2) A participant who has a baccalaureate degree or higher is considered employable. No further training shall be approved unless the participant's physical or mental status has changed to such an extent that the past education is no longer appropriate. The participant must provide supportive evidence from either a qualified medical or mental health professional or the state rehabilitation agency.

(3) A participant who has successfully completed a postsecondary educational program that provides less than a baccalaureate degree may be approved for further training if the participant meets one of the following criteria:

1. The previous training is in an occupation that is outdated.
2. The previous training is in a field where current labor market information or emerging business trends show little or no employment opportunity.
3. The training requested is a progression in a specific career that moves a participant from entry-level positions to higher levels of pay, skill, responsibility, or authority.
4. The participant's background makes employment in the area in which the participant is trained impossible.
5. Changes in the participant's physical or mental status make the past training no longer appropriate. The participant must provide supportive evidence from a qualified medical or mental health professional or the state rehabilitation agency.

i. Prerequisite courses required by the selected training program.

j. Remedial coursework for one term when needed as determined by testing conducted by the training facility.

k. Summer school.

93.8(4) *Nonapprovable activities.* Nonapprovable training activities shall not be included in the FIA. When an activity in which the participant is enrolled becomes nonapprovable, PROMISE JOBS shall cancel the current training plan and require the participant to renegotiate the FIA to include other activities. Form 470-0602, Notice of Decision: Services, shall be issued to inform the participant that the request for education is canceled. Nonapprovable activities include the following:

a. A course or training that the participant has previously completed.

b. Any course or training in a field in which the participant does not intend to seek employment after the training is completed. An exception may be made when the reason for not seeking employment is to receive further education when the education:

- (1) Is a planned progression in a specific career path; and
 - (2) Will not lead to an advanced degree beyond a baccalaureate.
- c.* A training program that does not relate to the identified vocational goal.

d. Educational activities for which the participant has failed to earn the grades required for admission.

e. Education in a field in which the participant will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.

f. Out-of-state training except as allowed under paragraph 93.8(3) "g."

g. Training for jobs paying less than state minimum wage.

h. Training that will not be completed until after the participant leaves FIP. Training programs that exceed the known length of time during which the participant will remain eligible for FIP assistance shall be approved only if:

(1) The time remaining in the training is minimal and tuition has already been paid.

(2) There is a reasonable plan for how the program will be completed without the assistance and support from FIP or PROMISE JOBS. A reasonable plan may include, but not be limited to, school loans, grants, and scholarships.

93.8(5) Training plan content. Once a participant is approved for training, a training plan shall be developed and written into the participant's FIA. The training plan shall include:

a. Academic enrollment hours. Participants are encouraged to maintain as full an academic workload as is possible in order to complete their education in a timely manner. However, a person may choose to participate in education along with other activities such as employment, job-seeking skills, or other FIA activities.

b. Approved training plan activities.

c. The specific educational goal as defined in paragraph 93.8(1) "a."

d. A date by which the participant expects to complete training. This end date depends on:

(1) Time frames specified for a program as established by the educational facility.

(2) Whether the participant is attending full-time or part-time.

(3) Problems or barriers to involvement as identified in subrule 93.4(5) or 93.14(1).

e. Testing schedule. Participants enrolled in ABE or ESL programs must be able to complete training in the time determined by the testing schedule unless the PROMISE JOBS worker and, if appropriate, the participant's academic advisor or instructor agree that additional time may be allowed. Under no circumstances, however, shall more than 6 additional months be allowed. Additional time shall not be allowed if, as a result, months required to complete training would exceed 24 months for ABE or 12 months for ESL.

93.8(6) Supportive payments. PROMISE JOBS may provide payment for certain expenses when needed to participate in approved education and training activities as described in this subrule and in subrule 93.11(4).

a. *Eligibility.*

(1) Eligibility for PROMISE JOBS supportive payments for education and training begins with the date when the participant begins training under an approved plan or is removed from a waiting list as described at paragraph 93.4(4) "d," whichever is later.

(2) Participant eligibility for payment of transportation and child care payments begins as described in subparagraph 93.8(6) "a"(1) and shall be terminated when a training plan is canceled.

(3) Each participant in postsecondary vocational training is limited to 24 fiscal months of PROMISE JOBS payment of expenses needed for participation. The 24 fiscal months do not have to be consecutive. See paragraph "b" of this subrule for additional limits on child care expenses.

(4) When more than one facility offers a particular program, payment is limited to the amount required to attend the nearest educational facility except when attending a facility that is farther away will allow the family to reach self-sufficiency earlier.

b. *Child care.* Participants assigned to educational activities shall receive a child care payment, if required, for each month or part thereof as described at subrule 93.11(2). EXCEPTION: Each PROMISE JOBS participant is limited to 24 fiscal months of child care assistance.

(1) All child care assistance payments issued under the PROMISE JOBS program count toward this limit.

(2) All child care assistance payments issued for child care provided on or after March 1, 2009, count toward this limit, including payments issued while the person was not a PROMISE JOBS participant, pursuant to 441—subparagraph 170.2(2) "b"(1).

c. *Transportation.* Participants assigned to educational activities shall receive a transportation payment for each month or part thereof as described at subrule 93.11(3) unless transportation payments are available from another source.

(1) When a participant receives a transportation payment from another program which equals or exceeds that possible under PROMISE JOBS, transportation shall not be paid by PROMISE JOBS for any month covered by the other program.

(2) When the amount received from another program is less than that possible under PROMISE JOBS, a supplemental payment may be made as long as the combined payment does not exceed that normally paid by PROMISE JOBS.

(3) When a participant is enrolled in high school, a transportation payment shall not be allowed if transportation is available from another source, such as the school district. If child care needs or the needs

of the child or the participant make it impractical or inappropriate for the participant to use transportation provided by the school district, a transportation payment may be authorized.

d. Training expenses. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or postsecondary vocational training may be eligible for payment of the following expenses of training when required for participation, subject to limits in subrule 93.11(4):

- (1) Enrollment fees,
- (2) School application fees,
- (3) Educational grant or scholarship application fees,
- (4) Licensing, certification and testing fees,
- (5) Travel costs required for certification or testing, and
- (6) Certain practicum expenses as described in subparagraph 93.11(4)“a”(3).

e. Direct education costs. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less may also be eligible for payment for direct education costs, including:

- (1) Tuition,
- (2) Books,
- (3) Fees including graduation,
- (4) Basic school supplies,
- (5) Specific supplies related to obtaining credit for a course and required of all students in a course, and
- (6) Required uniforms.

f. Supplies purchased with PROMISE JOBS funds. Participants who successfully complete their training plans may keep any books or supplies, including tools, which were purchased with PROMISE JOBS funds. Participants who leave their training program before completion and do not obtain training-related employment within 60 days of leaving training shall return all reusable supplies, including books and tools, but not clothing, purchased by PROMISE JOBS.

(1) The PROMISE JOBS worker is authorized to donate to nonprofit organizations any items determined to be unusable by the PROMISE JOBS program.

(2) When tools are not returned, the amount of the PROMISE JOBS payment shall be considered an overpayment unless the participant verifies theft of the tools through documentation of timely report to a law enforcement agency.

93.8(7) Documentation.

a. Plan. The following information shall be documented in the participant’s file.

- (1) Evaluation results, pursuant to paragraph 93.8(1)“b.”
- (2) Current educational level.
- (3) Justification for approval of additional postsecondary education pursuant to subrule 93.5(3).
- (4) Academic probationary status pursuant to subrule 93.8(8).
- (5) Justification for denial of education. Form 470-0602, Notice of Decision: Services, shall be issued to the participant to deny the request for education.

b. Participation. A participant shall provide documentation of the actual hours of participation in education and homework and of grades and academic progress as described in subrule 93.10(2).

93.8(8) Academic probation. A participant may be placed on academic probation for at least one term, or a comparable time limit appropriate to the educational program, after which the participant shall be reevaluated for continued inclusion in education activities. This subrule does not apply to parents under the age of 18 who are attending high school completion programs.

a. Placing a participant on academic probation. The PROMISE JOBS worker may choose to place a participant on academic probation in the following circumstances:

(1) The educational evaluation completed according to paragraph 93.8(1)“b” identifies some factors with the participant’s ability or past circumstances that could make successful completion of the training difficult but the participant’s motivation is high and changes in the participant’s life situation indicate a realistic probability of success.

(2) The participant was previously unable to maintain the cumulative grade point average required by a training facility in training comparable to that being requested.

(3) The participant enrolled but did not complete a previous education activity without good cause.

(4) At the end of a term, or of a comparable period applicable to the educational program, the participant is receiving less than a 2.0 grade point average or less than a higher average that is required by the specific training facility or curriculum.

b. Probation outcomes. The participant shall be removed from probation for satisfactory performance if, by the end of the established probationary period, the participant is receiving at least a 2.0 grade point average or a higher average as required by the specific training facility or curriculum.

(1) *Reevaluation.* If the participant is not receiving the required grade point by the end of the probationary period, the participant shall be reevaluated to determine continued eligibility for participation in education using the same type of information used to originally evaluate the likelihood of academic success as identified in paragraph 93.8(1)“*b.*” Documentation shall meet the requirements as stated in subrule 93.8(7).

(2) *Continued probation.* Probation may be continued when reevaluation indicates that education is appropriate. The PROMISE JOBS worker may also consider continued probation when:

1. Temporary barriers such as illness or family emergencies that interfered with successful participation have been resolved.

2. Long-term barriers to successful participation have been identified and accommodations developed and implemented.

3. The counselor or the lead instructor in the educational program verifies that there is an excellent likelihood the student will raise the grade point to the acceptable level in the next term or a comparable time limit appropriate to the educational program.

(3) *Cancellation of a training plan.* The participant’s current training plan shall be canceled if the participant has failed to maintain at least a 2.0 grade point average or a higher average required by the specific training facility or curriculum, and reevaluation indicates no mitigating circumstances as listed in subparagraph 93.8(8)“*b*”(2). When a training plan is canceled, the participant will be required to renegotiate the family investment agreement to include either a new, more appropriate training plan or other FIA activities. Form 470-0602, Notice of Decision: Services, shall be issued to the participant to inform the participant that the approval for education is canceled.

93.8(9) Limited benefit plan. Participants in education choose a limited benefit plan through the following actions.

a. Failure to participate. The participant fails to maintain education activities or follow training plan requirements as specified in the participant's FIA, and the participant does not have good cause. Procedures at rule 441—93.14(239B) shall apply.

b. Misuse of payments. The participant misuses expense payments to the extent that the training plan is no longer achievable or knowingly provides receipts or any other written statements that have been altered, forged, or, in any way, are not authentic.

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441—93.9(239B) Other FIA activities.

93.9(1) Parenting skills training.

a. Parents aged 20 or older. For parents who are aged 20 or older when the FIA is signed, activities that strengthen the participant’s ability to be a better parent can be considered approvable training under PROMISE JOBS and may be included in the FIA as long as the participant is active in at least one other PROMISE JOBS component. Parents aged 20 or older who do not carry out the parenting skills training described in the FIA shall be considered to have chosen the limited benefit plan, unless family circumstances warrant renegotiation and amendment of the FIA.

b. Parents aged 19 or younger. Parents aged 19 or younger when the FIA is signed are required to include parenting skills training in the FIA, but may be excused from the requirement when documentation of satisfactory completion of parenting skills training is provided before the FIA is signed.

(1) Priority for orientation or assessment. In any month, PROMISE JOBS shall give priority for orientation or assessment services to parents who are already aged 19 in order to establish their responsibility for parenting classes before they are aged 20. This applies to those who are scheduled for orientation, to those who are still in assessment, and to those who have an FIA that must be renegotiated and amended.

(2) FIA requirement. The FIA shall be written or renegotiated and amended to include specific plans for parenting skills training and shall identify the training provider's name and beginning and ending dates of the training. The scheduled training may be in the future to accommodate availability of provider resources. However, it shall occur as soon as is compatible with the circumstances of the family, the other activities in the FIA, and the availability of provider resources, except as specified at paragraph 93.4(4) "d."

(3) Parents aged 19 or younger who are participating in a parenting skills training program at the time the FIA is signed shall be allowed to continue in that program, if they choose, as long as the provider is listed in paragraph 93.9(1) "c" or meets the requirements of paragraph 93.9(1) "c" and documentation of enrollment is provided. The time frames as described in paragraph 93.9(1) "d" shall be used to determine the remaining training time to be included in the FIA.

(4) Participation in other activities. Parents aged 19 or younger are not required to be participating in another PROMISE JOBS component to be eligible for parenting skills training. Other PROMISE JOBS components are included in the FIA according to policies at subrule 93.4(4).

c. Approved providers. The sources listed in this paragraph are approvable providers for parenting skills training.

(1) High school departments of family and consumer sciences that offer child development, family relationships, or parenting classes and alternative high school programs for pregnant and parenting teens. Services shall be limited to a minimum of one semester and a maximum of two semesters.

(2) Community colleges, other associate-degree institutions, and baccalaureate-degree institutions that offer child development, family relationships, or parenting classes. Services shall be limited to one semester or two quarters.

(3) Area education agencies; child abuse prevention programs; child and adult food program sponsors; child care resource and referral agencies; family resource centers; maternal and child health centers; family development and self-sufficiency program grantees and other family development providers; Head Start, Head Start parent and child centers, and Early Head Start programs; Iowa State University Extension services such as, but not limit to, the "Best Beginnings" program; private nonprofit social service agencies; and young parent support and information organizations. Services shall be limited to:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
 2. A maximum of 26 contact hours or six calendar months, whichever comes first.
- d. Other providers of parenting skills training are approvable as long as they:

(1) Have five of these six elements: child growth and development, child health and nutrition, child safety, positive discipline, relationships, and life skills.

(2) Offer training within the following time frames:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

e. Supportive payments. For participants described in paragraphs 93.9(1) "a" and 93.9(1) "b," a child care payment and a transportation payment for each month of participation, or part thereof, as described at subrule 93.11(3), shall be paid if these services are not available from another entity and are required for participation.

(1) Other expenses. Payment for tuition, fees, or books and supplies shall be made only when parenting skills training is not available from a free source in the local area. PROMISE JOBS shall not pay for any expenses that are covered by student financial aid in postsecondary educational institutions as provided elsewhere in these rules.

(2) Continuation of payments. If the participant chooses to continue with the parenting skills training program beyond the designated period of participation described in paragraph 93.9(1) "c,"

PROMISE JOBS responsibility for payment of expense payments shall not extend beyond the designated period unless completion is delayed by acceptable instances for nonparticipation as stipulated at rule 441—93.14(239B) or barriers to participation at subrule 93.4(5).

f. Participation in parenting skills training. The planned duration of the parenting skills training shall be determined by agreement between the participant and the training provider within the limits described in paragraphs 93.9(1)“c” and 93.9(1)“d.”

(1) In consultation with the PROMISE JOBS worker, the participant and the provider shall design a written agreement and provide a copy to PROMISE JOBS. The agreement shall designate the period during which the mandatory parenting skills training requirement will be fulfilled. The period specified in the agreement or notice of decision shall be included in the FIA.

(2) Participants who fail to carry out this step in the FIA shall be considered to have chosen the limited benefit plan.

g. Failure to complete parenting skills training. Parents aged 19 or younger who do not include parenting skills training in the FIA or do not carry out the parenting skills training described in the FIA shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.9(2) Family development. Family development services are support services for PROMISE JOBS families at risk of long-term dependency on public assistance. The services are designed to promote, empower, and nurture the family to self-sufficiency and healthy reintegration into the community.

a. PROMISE JOBS may arrange for family development services from entities that meet one of the following criteria wherever these are available. Family development services shall be:

(1) Provided by a family development specialist certified by the University of Iowa College of Social Work, National Resource Center on Family-Based Services; or

(2) Provided under a plan that has been approved by the family development and self-sufficiency (FaDSS) council of the department of human rights.

b. Inclusion of family development services by participants as a family investment agreement activity is voluntary except for unmarried parents aged 17 and younger who do not live with a parent or legal guardian as described at subparagraph 93.4(4)“c”(4).

93.9(3) Family planning counseling. Referral for family planning counseling is an optional service that shall be offered to each applicant or participant. It is not a component of PROMISE JOBS.

a. The department of human services worker or the PROMISE JOBS worker shall:

(1) Discuss orally and in writing the financial implications of newly born children on the participant’s family during PROMISE JOBS orientation or assessment, using a form approved by the department; and

(2) Review information about the basics of family planning; and

(3) Provide a listing of resources in the participant’s county of residence or the service delivery area.

b. The FIA shall record participant response to the option of referral for family planning counseling. It is not acceptable for the FIA to have family planning counseling as the only step of the FIA.

c. Supportive payments. No supportive payments are allowed for family planning counseling.

d. Participation. Limited benefit plan policies do not apply to participants who choose not to include family planning counseling in the FIA or who do not carry out the steps of family planning counseling.

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.10(239B) Required documentation and verification.

93.10(1) Written notification to participants.

a. *Notice of meetings, assignments, and issues.* PROMISE JOBS shall notify participants in writing of all scheduled meetings, of FIA activity and work-site assignments, and of any participation issues as described at rule 441—93.13(239B). PROMISE JOBS shall also notify the participant in

writing when the participant is required to provide medical documentation, verification of hours of participation, employment verification, or any other verification.

(1) PROMISE JOBS shall allow a participant five working days from the date notice is mailed to appear for scheduled meetings unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(2) PROMISE JOBS shall allow a participant five working days from the date notice is mailed to appear for an FIA activity or work-site assignment or to provide medical documentation, employment verification, or any other verification, except as otherwise specified in 93.10(2).

(3) PROMISE JOBS shall allow additional time upon request from the participant when the participant is making every effort but is unable to fulfill requirements within the established time frame.

b. Notice of decision. PROMISE JOBS shall send written notice to each participant in accordance with 441—Chapter 16 when services are approved, rejected, renewed, changed, canceled, or terminated for failure to cooperate or participate. PROMISE JOBS services are approved when the participant is assigned to begin participation in an activity as written in the FIA.

93.10(2) Verification of participation and progress. Hours of participation and a participant's progress in FIA activities must be documented and verified. When the participant is responsible for providing the verification, PROMISE JOBS shall notify the participant in writing as required in subrule 93.10(1).

a. FIA activities directly monitored by PROMISE JOBS. When the FIA activities are provided or directly monitored by PROMISE JOBS staff, such as job club or workplace essentials, the staff will document the participant's hours of attendance and progress in the case file.

b. FIA activities not directly monitored by PROMISE JOBS. When FIA activities are provided by a service provider other than PROMISE JOBS, the provider shall verify the participant's hours of attendance with Form 470-2617, PROMISE JOBS Time and Attendance Report, unless another method is required by this rule.

(1) The provider is expected to specify the participant's hours of attendance and to sign and date the Time and Attendance Report.

(2) The participant is responsible for providing the signed and dated form to PROMISE JOBS within ten calendar days following the end of each month, unless the provider provides the form to PROMISE JOBS within this time frame.

(3) EXCEPTION: If the participant is under age 20 and in high school or high school equivalency classes, the participant may verify the hours by completing and submitting the PROMISE JOBS Time and Attendance Report monthly. The training provider does not need to sign the form.

c. Documentation of job search. The participant shall complete and provide documentation of any job search activities that cannot be verified by the PROMISE JOBS worker. The participant shall provide Form 470-3099, Job Search Record, within ten calendar days following the end of each month during which the participant has made a job search. The PROMISE JOBS worker shall consider the Job Search Record complete if the form includes:

(1) Sufficient information to identify the employer that was contacted or the activity that was completed,

(2) The date that the contact was made or the date the activity was completed,

(3) The amount of time spent, and

(4) The participant's signature.

d. Employment verification. Participants shall verify actual hours of employment at the time that employment begins, upon FIP approval if employed at the time of application, when changes in hours occur, and no less than once every six months thereafter. Participants may use employer statements or copies of pay stubs, Employer Statement of Earnings Form 470-2844, or may sign Form 470-0429, Consent to Obtain and Release Information, so that the employer may provide information directly to the PROMISE JOBS worker. Participants shall provide verification of actual hours of employment within five working days of the written request from PROMISE JOBS.

e. Documentation of self-employment. At the time of the participant's FIA review, a self-employed participant shall provide documentation of actual hours worked and gross income and business expenses

from the last 30 days. Data from more than 30 days may be requested if the last month is not indicative of normal business. The participant shall provide documentation within five working days of the written request from PROMISE JOBS.

f. Distance learning. When a participant is involved in a distance-learning program, PROMISE JOBS will accept the documentation issued by the distance-learning institution verifying that the student participated in the sessions.

(1) Documentation may include the attendance records or log-in and log-out records available on line or in an electronic format. Documentation may also be obtained through an agreement with a support agency that monitors the student's actual participation.

(2) The participant is responsible for providing the documentation within ten calendar days following the end of each month unless the institution provides the documentation to PROMISE JOBS within this time frame.

g. Failure to provide required documentation or verification. Participants who fail to provide documentation or verification as described in this subrule after written notification from PROMISE JOBS as described in subrule 93.10(1) shall be considered to have chosen the limited benefit plan. Procedures at rule 441—93.14(239B) shall apply.

93.10(3) Verification of problems or barriers. Participants may be required to provide written verification or supporting documentation of reported problems or barriers to participation, such as but not limited to lack of transportation, family emergency, or existence of a mental or physical disability or limitation or substance abuse.

a. Medical documentation. A participant shall secure and provide written documentation signed by a qualified medical or mental health professional to verify a claimed illness or disability within five working days of a written request by PROMISE JOBS. This time limit may be extended due to individual circumstances, such as the need to obtain an updated evaluation. Acceptable verification includes Form 470-0447, Report on Incapacity, or other statement signed by a qualified medical or mental health professional to verify the existence of an illness, disability, or limitation.

b. Other documentation. A participant shall secure and provide written documentation to verify a claimed problem or barrier to participation within five working days of a written request by PROMISE JOBS. Acceptable documentation may include a signed statement from a third party with knowledge of the problem or barrier.

c. Failure to verify problem or barrier or to provide medical documentation. Failure to provide verification of a problem or barrier or to provide medical documentation as described at subrule 93.10(3) does not directly result in the imposition of a limited benefit plan. Examples of actions that do not directly result in a limited benefit plan include, but are not limited to, failure to provide Form 470-0447, Report on Incapacity, or other statement from a medical or mental health professional to verify the existence of an illness or disability, or a statement from a third party with knowledge about the problem or barrier.

(1) Participants who claim an inability to participate on a full-time basis due to a claimed problem or barrier and who fail to provide verification or medical documentation upon written request may be required to renegotiate the FIA to include full-time participation in FIA activities. Failure to renegotiate the FIA may result in a limited benefit plan.

(2) Participants who claim a problem or barrier caused their failure to participate for the full number of hours identified in their FIA and who fail to provide verification of the problem or barrier or medical documentation upon written request may not be excused for the failure to participate. If the failure is not excused, the failure will result in imposition of a limited benefit plan if the failure meets the criteria described at subrule 93.13(2).

[ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1694C, IAB 10/29/14, effective 1/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—93.11(239B) Supportive payments. In order to facilitate successful participation, PROMISE JOBS may provide payment for the expenses listed in this rule. Participants shall submit Form 470-0510, Estimate of Cost, to initiate payments or change the amount of payment for expenses other than child care.

93.11(1) Eligibility. Participants are eligible for supportive payments needed for participation in activities in their FIA, subject to the limits in this chapter.

a. Applicants in a limited benefit plan who must complete significant contact with or action in regard to PROMISE JOBS for FIP eligibility to be considered, as described at 441—paragraphs 41.24(8) “*a*” and “*d*,” are eligible for expense payments for the 20 hours of activity. However, PROMISE JOBS services and supportive payments are only available when it appears the applicant will otherwise be eligible for FIP.

b. Applicants who have received 60 months of FIP are eligible for PROMISE JOBS services and payments under the circumstances described at 441—subrule 41.30(3).

93.11(2) Child care. Payments for child care shall be issued through the child care assistance program as described at 441—Chapter 170.

a. Payment shall be provided for child care if:

- (1) Care is needed for participation in any PROMISE JOBS activity other than orientation,
- (2) Payment is not specifically prohibited elsewhere in these rules, and
- (3) Payment is not available from another source.

b. Payment shall be issued to the child care provider after the service has been received, as described in 441—subrule 170.4(7).

93.11(3) Transportation. Participants may receive a transportation payment for each day that transportation is needed for participation in a PROMISE JOBS activity. Transportation payments shall be determined according to the circumstances of each participant. If necessary, payments shall cover transportation for the participant and child from the participant’s home to the child care provider and to the PROMISE JOBS site or activity.

a. Exclusions.

(1) A transportation payment is not available for orientation or for assessment activities that occur on the same day as orientation.

(2) A transportation payment is not available for employment. Participants who are employed shall be entitled to the work expense deduction described at 441—paragraph 41.27(2) “*a*” to cover transportation costs associated with employment.

b. Rate of payment. Payments shall not exceed the rate that the provider would charge a private individual.

(1) Public transportation. For those who use public transportation, the payment shall be based on the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment, using the rate schedules of the local transit authority to the greatest advantage, including use of weekly and monthly passes or other rate reduction opportunities.

(2) Private transportation. For participants who use a privately owned motor vehicle or who hire private transportation, the transportation payment shall be based on a formula which uses the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment multiplied by the participant’s anticipated daily round-trip miles and then multiplied by the mileage rate of 30 cents per mile.

c. Special transportation needs. Participants who require, due to a mental or physical disability, a mode of transportation other than a vehicle they operate themselves shall be eligible for payment of a supplemental transportation payment when documented actual transportation costs are greater than transportation payments provided under these rules and transportation is not available from another source.

(1) Medical evidence. To be eligible for a supplemental payment, the participant must provide medical evidence of the need for an alternate mode of transportation due to disability or incapacity. EXCEPTION: A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of disability. The evidence must be from a qualified medical or mental health professional or the state rehabilitation agency. The evidence may be submitted either by letter from the qualified medical or mental health professional or on Form 470-0447, Report on Incapacity.

(2) Resources for examination. When an examination is required and other resources are not available to meet the expense of the examination, the PROMISE JOBS worker shall authorize the examination and submit a claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

(3) Payment rates. Actual costs of transportation by a public or private agency shall be allowed. Costs of transportation provided by private automobile shall be allowed as described in subparagraph 93.11(3)“b”(2).

d. Issuance of payments. The transportation payment shall be issued before the first scheduled day of participation in an activity. For participants in the same activity for more than one month, transportation payments shall be issued before the first day of the month of scheduled participation except as described below.

(1) Transportation payments for assessment shall be issued in advance in weekly increments, with payments for the second or third week of assessment being issued as soon as it is determined that the participant will be required to participate in the second or third week of assessment.

(2) Payments for the third and subsequent months of an ongoing activity shall not be authorized before receipt of time and attendance verification, as described at subrule 93.10(2), for the month before the issuance month. EXAMPLE: A transportation payment for June, normally issued after May 15 to be available to the participant by June 1, will not be authorized until time and attendance verification for the month of April has been received in the PROMISE JOBS office.

(3) The amounts of payments for the third and subsequent months of an ongoing activity shall be adjusted by subtracting from normally scheduled days any number of days which represents a difference between the number of scheduled days of activity in the month before the issuance month and the number of actual days attended in that month. EXAMPLE: A transportation payment is issued in May based on 16 scheduled days of participation for June. The participant attends only 14 days of the activity. When preparing to issue the August transportation allowance, the worker subtracts two days from the normally scheduled August activities to calculate the payment. If ten days of participation are scheduled, the transportation payment issued in July for August is calculated using eight days.

(4) Because adjustment for actual attendance is not possible in the last two months of an ongoing activity, transportation payments for the last two months of an ongoing activity shall be subject to transportation overpayment provisions of paragraph 93.11(3)“e.”

EXCEPTION: A transportation overpayment does not occur for any month in which the participant leaves the PROMISE JOBS activity in order to enter employment.

e. Transportation overpayment. Payment for transportation shall be considered an overpayment subject to recovery in accordance with rule 441—93.12(239B) in the following instances:

(1) When the participant attends none of the scheduled days of participation in a PROMISE JOBS activity, the entire transportation payment shall be considered an overpayment. Recovery of the overpayment shall be initiated when it becomes clear that subsequent participation in the activity is not possible for reasons such as, but not limited to, family investment program ineligibility, establishment of a limited benefit plan, or exemption from PROMISE JOBS participation requirements.

(2) When the participant fails to attend 75 percent of the normally scheduled days of participation in either of the last two months of an ongoing PROMISE JOBS activity or in any transportation payment period of an activity which has not been used for payment adjustment as described at paragraph 93.11(3)“d,” an overpayment is considered to have occurred. The amount to recover shall be the difference between the amount for the actual number of days attended and the amount for 75 percent of normally scheduled days.

93.11(4) Training and education expenses. Participants shall use PROMISE JOBS payments that they receive to pay authorized expenses.

a. Classroom training. PROMISE JOBS payments for classroom training are limited as follows:

(1) Tuition payments for high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less shall not exceed the rate charged by the Iowa community college located nearest the participant’s residence which offers a course or program comparable to the one in which the participant plans to enroll. If an Iowa community college does not

offer a comparable program, the maximum tuition rate payment shall not exceed the Iowa resident rate charged by the out-of-state area school located nearest the participant's residence.

(2) A standard payment for basic school supplies of \$10 per term or actual cost, whichever is higher, shall be allowed for those participants who request it. A claim for actual costs higher than \$10 must be verified by receipts.

(3) A per diem payment of \$10 for living costs during a practicum shall be allowed when the practicum is required by the curriculum of the training facility, would require a round-trip commuting time of three hours or more per day, and is not available closer to the participant's home. If practicum earnings or other assistance is available to meet practicum living costs, no payment shall be made.

(4) Payments may be authorized to meet the costs of travel required for certification and testing, not to exceed the transportation payment as described at subrule 93.11(3) and the current state employee reimbursement rate for meals and lodging.

(5) Funds may not be used to purchase supplies to enable a participant to begin a private business.

(6) No payment shall be made for jewelry, pictures, rental of graduation gowns, elective courses that require expenditures for field trips or special equipment, such as photography or art supplies, or other items that are not required to complete training for a vocational goal.

b. Retroactive payments. Retroactive payments for transportation and allowable direct education costs shall be allowed only under the following conditions:

(1) If plan approval or removal from a waiting list occurs after the start of the term due to administrative delay or worker delay, payments shall be approved retroactive to the start of the term for which the plan is approved or removal from the waiting list is authorized. If the participant has already paid costs with private resources, the participant shall be reimbursed.

(2) If plan approval is delayed due to the fault of the participant, payment eligibility shall begin with the first day of the month during which the plan is approved or the month in which the participant is removed from a waiting list as described at paragraph 93.4(4) "d," whichever is later. In this instance, there shall be no reimbursement for costs already paid by the participant.

c. Receipts. Participants shall furnish receipts for expenditures that they pay, except for transportation payments. Failure to provide receipts will preclude additional payments. Receipts may be requested for payments paid directly to the training provider if the PROMISE JOBS worker determines it is appropriate.

d. Payments directly to facility. PROMISE JOBS is authorized to provide payment for expenses allowable under these rules to the training facility for the educational expenses of tuition and fees and books and supplies which are provided by the facility and billed to the PROMISE JOBS participant. Payment may also be made to the participant in those situations where payment to the participant is determined to be appropriate by the PROMISE JOBS worker.

93.11(5) Other expenses.

a. Birth certificates. PROMISE JOBS funds shall be used to pay costs of obtaining a birth certificate when the birth certificate is needed in order for the participant to complete the workforce development registration process described in subrule 93.3(6).

b. Required clothing and equipment. A participant may receive up to a limit of \$100 per work-site assignment for clothing or equipment if required by the work experience site and not covered by the sponsor.

c. Workers' compensation. The department of human services shall provide workers' compensation coverage for all PROMISE JOBS work experience participants.

d. Workforce Investment Act. PROMISE JOBS funds may also be used to pay expenses for PROMISE JOBS participants enrolled in federal Workforce Investment Act (WIA) funded services or activities when those expenses are allowable under these rules.

[ARC 8346B, IAB 12/2/09, effective 12/1/09; ARC 8557B, IAB 3/10/10, effective 4/14/10; ARC 1694C, IAB 10/29/14, effective 1/1/15]

441—93.12(239B) Recovery of PROMISE JOBS expense payments. When an applicant, a participant, or a provider receives an expense payment for transportation or other supportive expenses

that is greater than allowed under these rules or receives a duplicate payment of an expense payment, an overpayment is considered to have occurred and recovery is required. There are two categories of PROMISE JOBS expense payments subject to recovery: (1) transportation, and (2) other supportive expense payments.

93.12(1) The PROMISE JOBS worker shall notify the department of inspections and appeals (DIA) to record the overpayment in the overpayment recovery system. The outstanding balance of any overpayments that occurred before July 1, 1990, shall be treated in the same manner.

93.12(2) The department of inspections and appeals shall notify the participant or the provider when it is determined that an overpayment exists, as described at 441—paragraph 7.4(3)“i.”

a. Notification shall include the amount, date, and reason for the overpayment. Upon the participant’s request, the local office shall provide additional information regarding the computation of the overpayment.

b. The participant may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—paragraph 7.4(3)“i.” If a participant or provider files an appeal request, the PROMISE JOBS unit shall notify the DIA within three working days of receipt of the appeal request.

93.12(3) A PROMISE JOBS overpayment shall be recovered through repayment in part or in full. Repayments received by the PROMISE JOBS unit shall be transmitted to the Department of Human Services, Cashier’s Office, Room 14, 1305 E. Walnut Street, Des Moines, Iowa 50319-0144.

a. Overpayments of PROMISE JOBS child care issued for any month before July 1999 shall be subject to recovery rules of the PROMISE JOBS program.

b. Overpayments of child care assistance issued for July 1999, and any month thereafter, are subject to recovery rules of the child care assistance program set forth in rule 441—170.9(234).

93.12(4) When a participant or a provider offers repayment in part or in full before the end of the 30-day appeal period, the PROMISE JOBS unit or the department of human services’ local office shall accept the payment. If a subsequent appeal request is received, the PROMISE JOBS unit shall notify the DIA and shall not accept any further payments on the claim. The amount of the voluntary payment shall not be returned to the participant or provider unless the final decision on the appeal directs the department to do so.

93.12(5) When a participant or a provider has been referred to the DIA to initiate recovery, the DIA shall use the same methods of recovery as are used for the FIP program, described at DIA administrative rules 481—71.1(10A) to 71.9(10A), except that the FIP grant shall not be reduced to effect recovery without the participant’s written permission.

a. When the participant requests grant reduction on Form 470-0495, Repayment Contract, the grant will be reduced for repayment as described in 441—subrule 46.25(3), paragraphs “a,”“b,” and “c.”

b. The DIA is authorized to take any reasonable action to effect recovery of provider overpayments such as, but not limited to, informal agreements, civil action, or criminal prosecution. However, the DIA shall not take any collection action on a provider overpayment that would jeopardize the participant’s continued participation in the PROMISE JOBS program.

[ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—93.13(239B) Resolution of participation issues. PROMISE JOBS participants who do not carry out the responsibilities of the FIA shall be considered to have chosen the limited benefit plan, as described at 441—subrule 41.24(8). The participation issues listed in this rule are those that are important for effective functioning in the workplace or training facility and for the completion of the FIA.

93.13(1) Notification of participation issue. When participants appear to be choosing a limited benefit plan by not carrying out the FIA responsibilities, the PROMISE JOBS worker shall send one written reminder or letter as specified in subrule 93.10(1). The reminder or letter shall:

- a.* Clearly identify the participation issue and the specific action needed to resolve it,
- b.* Clarify expectations,
- c.* Attempt to identify barriers to participation that should be addressed in the FIA,

- d. Explain the consequences of the limited benefit plan, and
- e. Offer supervisory intervention.

93.13(2) Participation issues. Actions that may cause participants to be considered as having chosen the limited benefit plan when the participant does not have a problem or barrier to participation as defined at paragraph 93.4(5) “a” or rule 441—93.14(239B) are:

a. *Tardiness.* Participants who are more than 15 minutes late to a scheduled FIA activity for a third time within three months of the first tardiness, after receiving one written reminder at the time the second tardiness occurred.

b. *Failure to attend scheduled activities.* Participants who do not, for a second time after receiving one written reminder at the first occurrence, appear for scheduled appointments, participate in assessment activities, including taking required vocational or aptitude tests, complete or provide required forms other than those described at subrule 93.10(3) or are absent from activities designated in the FIA.

c. *Absence from work experience.* Participants who do not, for a second time after receiving one written reminder at the first occurrence, notify work experience sponsors or the PROMISE JOBS worker of an absence within one hour of the time at which they are due to appear.

d. *Disruptive behavior.* Participants who exhibit disruptive behavior for a second time after receiving one written reminder at the first occurrence. “Disruptive behavior” means the participant hinders the performance of other participants or staff, refuses to follow instructions, uses abusive language, or is under the influence of alcohol or drugs.

e. *Unsatisfactory performance or participation.* Participants whose performance or participation in an FIA activity continues to be unsatisfactory after PROMISE JOBS sends one letter as described in subrule 93.13(1).

f. *Physical threats.* Participants who make physical threats to other participants or staff and do not demonstrate that the participant is not at fault by providing written documentation from a doctor, licensed psychologist, probation officer, or law enforcement official after PROMISE JOBS sends one letter as described in subrule 93.13(1).

(1) “Physical threat” means having a dangerous weapon in one’s possession and either threatening with or using the weapon or committing assault.

(2) The documentation must verify that the act was caused by either a temporary problem or a serious problem or barrier that needs to be included in the FIA. The documentation must also provide reasonable assurance that the threatening behavior will not occur again.

g. *Accepting work experience assignments.* Participants who do not accept work experience assignments when the work experience is part of the FIA and do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one letter.

h. *Work experience interviews.* Participants who do not appear for work experience interviews for a second time after receiving a written reminder at the first occurrence.

i. *Employment and other work activity issues.* Participants who do not follow up on job referrals, who refuse offers of employment or other work activity, who reduce hours of employment or other work activity, who terminate employment or other work activity, or who are discharged from employment or other work activity due to misconduct.

(1) For the purposes of these rules, “misconduct” means a deliberate act or omission by the employed participant that constitutes a material breach of the duties and obligations arising out of the employee’s contract of employment. To be considered misconduct, the employee’s conduct must demonstrate deliberate violation or disregard of standards of behavior that the employer has the right to expect of employees. Mere inefficiency, unsatisfactory conduct, failure to perform well due to inability or incapacity, ordinary negligence in isolated instances, or good-faith errors in judgment or discretion shall not be deemed misconduct for the purpose of these rules.

(2) At the time of the occurrence, PROMISE JOBS shall send a letter to the participant regarding the misconduct. The letter shall give the participant an opportunity to resolve the issue by accepting a previously refused employment offer if available, returning to previously terminated employment if available, obtaining comparable employment, or demonstrating a problem or barrier that caused the failure.

j. Failure to secure child care. Participants who do not secure adequate child care when registered or licensed facilities are available after PROMISE JOBS sends one written reminder and when PROMISE JOBS has provided the participant with resources for locating adequate child care.

k. Inappropriate use of funds. Participants for whom child care, transportation, or educational services become unavailable as a result of failure to use PROMISE JOBS funds or child care assistance funds to pay the provider or failure to provide required receipts and who do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one letter.

l. Failure to follow training plan. Education participants who do not follow the requirements of a training plan in the FIA as described at rule 441—93.8(239B).

m. Failure to renegotiate the FIA. When a participant fails to respond to the PROMISE JOBS worker's request to renegotiate the FIA because the participant has not attained self-sufficiency by the date established in the FIA, a limited benefit plan shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the FIA.

93.13(3) Choosing a limited benefit plan.

a. Before determining that a participant has chosen the limited benefit plan due to a potential participation issue, the PROMISE JOBS worker shall make every effort to negotiate a solution. Local PROMISE JOBS management has the option to involve an impartial third party to assist in a resolution process. Arrangements shall be indicated in the local services plan of the local service delivery region. As part of the resolution process, the PROMISE JOBS worker shall determine:

(1) Whether the participant has a problem that provides good cause for the participation issue, as described in rule 441—93.14(239B). If so, the participant shall be encouraged to take actions to fulfill the FIA.

(2) Whether participant circumstances indicate that a barrier to participation exists, as described in subrule 93.4(5). If so, the FIA shall be negotiated to address the barrier.

b. The participant may be considered to have chosen the limited benefit plan when all of the following occur:

(1) The participant is notified of a participation issue as described in subrule 93.13(1);
 (2) The participant does not resolve the participation issue;
 (3) The participant does not present acceptable evidence of a problem providing good cause for the issue as described in rule 441—93.14(239B); and

(4) The participant does not present acceptable evidence of a barrier to participation as described in subrule 93.4(5) or fails to renegotiate the FIA to address the identified barrier.

c. If the resolution process does not lead to fulfillment of the FIA, the case shall be referred for review by the administering or contracted service provider agency.

(1) The procedure may include review by state-level staff of the administering or contracted agency or by a regional PROMISE JOBS manager, a PROMISE JOBS supervisor, an income maintenance supervisor, or a combination of any of the above. Approval of any review procedure at less than the state level shall occur only after the service delivery region demonstrates satisfactory performance of the resolution process.

(2) The department of human services retains control and oversees review procedures even when another agency is contracted with to provide PROMISE JOBS services.

d. If the above steps do not lead to fulfillment of the FIA, the FIP participant is considered to have chosen the limited benefit plan and the notice of decision shall be initiated. The notice of decision shall inform the participant of:

(1) The action needed to reconsider the limited benefit plan as described at 441—subparagraph 41.24(8)“d”(1).

(2) Appeal rights under the limited benefit plan are described at rule 441—93.15(239B).

[ARC 1146C, IAB 10/30/13, effective 1/1/14; ARC 1208C, IAB 12/11/13, effective 2/1/14]

441—93.14(239B) Problems that may provide good cause for participation issues.

93.14(1) Problems leading to less than full participation. Problems affecting participation shall be considered to be of a temporary or incidental nature when the participation can easily be resumed. The

following problems may provide good cause for participation of less than the full number of hours identified in the FIA. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described at subrule 93.10(3):

- a. Illness of the participant. When a participant is ill more than three consecutive days or if illness is habitual, the PROMISE JOBS worker may require medical documentation of the illness.
- b. Illness of family member. When a participant is required in the home due to illness of another family member, the PROMISE JOBS worker may require medical documentation.
- c. Family emergency, using reasonable standards of an employer.
- d. Bad weather, using reasonable standards of an employer.
- e. Absence or tardiness due to participant's or spouse's job interview. When possible, the participant shall provide notice of the interview at least 24 hours in advance including the name and address of the employer conducting the interview. When 24-hour notice is not possible, notice must be given as soon as possible and before the interview.
- f. Leave due to the birth of a child. When a child is born after referral, necessary absence shall be determined in accordance with the Family Leave Act of 1993.
- g. Court appearance.
- h. Attendance at school functions of the participant's children or children in the participant's household.
- i. Attendance at required meetings with the department of human services or PROMISE JOBS.
- j. Absence due to up to ten holidays per year.

(1) The participant must normally have been scheduled to work, or participate in an unpaid work activity on the given day and the work site or facility is closed due to a holiday, or open but the participant is allowed to take the participant's normally scheduled hours off on a different day.

(2) The holidays included are New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Fourth of July, Labor Day, Veterans Day, Thanksgiving, the day after Thanksgiving, and Christmas.

93.14(2) Problems leading to refusing or quitting a job or limiting or reducing hours. The following problems may provide good cause for participation issues of refusing or quitting a job or limiting or reducing hours. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described at subrule 93.10(3):

- a. Required travel time from home to the job or available work experience or unpaid community service site exceeds one hour each way. This includes additional travel time necessary to take a child to a child care provider.
- b. Except as described in 441—subrule 41.25(5), work offered is at a site subject to a strike or lockout, unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A, commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).
- c. The work site violates applicable state or federal health and safety standards or workers' compensation insurance is not provided.
- d. The job is contrary to the participant's religious or ethical beliefs.
- e. The participant is required to join, resign from or refrain from joining a legitimate labor organization.
- f. Work requirements are beyond the mental or physical capabilities as documented by medical evidence or other reliable sources.
- g. Discrimination by an employer based on age, race, sex, color, disability, religion, national origin or political beliefs.
- h. Work demands or conditions render continued employment unreasonable, such as working without being paid on schedule.
- i. Circumstances beyond the control of the participant, such as interruption of regular mail delivery or other disruptions of services.
- j. Employment change or termination is part of the FIA.
- k. Job does not pay at least the minimum amount customary for the same work in the community.

l. The participant terminates employment in order to take a better-paying job, even though hours of the new job may be less than those in the previous job.

m. The employment would result in the family of the participant experiencing a net loss of cash income. Net loss of cash income results if the family's gross income less necessary work-related expenses is less than the cash assistance the person was receiving at the time the offer of employment is made. Gross income includes, but is not limited to, earnings, unearned income, and cash assistance. Gross income does not include food stamp benefits and in-kind income.

n. The employment changes substantially from the terms of hire, such as a change in work hours or work shift or a decrease in pay rate.

93.14(3) Other problems. The PROMISE JOBS worker may identify circumstances that could negatively impact the participant's achievement of self-sufficiency that are not described in subrule 93.14(1) or 93.14(2). When this occurs, the case shall be referred to the administrator of the division of financial, health and work supports for a determination as to whether the problems are acceptable reasons for:

a. Not participating,

b. Refusing or quitting a job, or

c. Discharge from employment due to misconduct as described at paragraph 93.13(2) "i."

[ARC 1146C, IAB 10/30/13, effective 1/1/14]

441—93.15(239B) Right of appeal. In accordance with 441—Chapter 7, each applicant or participant is entitled to appeal and to be granted a hearing over disputes regarding: (1) services being received; (2) services which have been requested and denied, reduced, canceled, or inadequately provided; and (3) acts of discrimination on the basis of race, sex, national origin, religion, age or handicapping condition.

93.15(1) Informal resolution process. When there is a disagreement between the participant and the immediate PROMISE JOBS worker regarding the participant's FIA or participation in PROMISE JOBS components, the participant may request an interview with the supervisor and a decision on the dispute. The supervisor shall schedule a face-to-face interview with the participant within 7 days and issue a decision in writing within 14 days of the participant's request.

93.15(2) Appeal on the content of the family investment agreement. A participant shall have the right to appeal the content of the FIA when the informal resolution process described at subrule 93.15(1) does not resolve a disagreement between the participant and the PROMISE JOBS worker.

93.15(3) Appeal of an alleged violation of PROMISE JOBS program policy. Participants shall have the right to file a written appeal concerning any alleged violation of a PROMISE JOBS program policy that is imposed as a condition of participation. The responsible agency shall provide the participant with written documentation that specifies the participation requirement in dispute.

93.15(4) Appeal rights under the limited benefit plan. A participant has the right to appeal the establishment of the limited benefit plan only once, at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

93.15(5) Request for a hearing on work conditions or availability of workers' compensation coverage. A participant who is enrolled in the PROMISE JOBS program may request a hearing if dissatisfied with working conditions, the availability of workers' compensation coverage or the wage rate used in determining hours of work experience program participation.

a. When any involved party is dissatisfied with the department's final decision, the dissatisfied party shall be informed of the right to appeal the issue to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, Vanguard Building, Room 600, 111 20th Street N.W., Washington, DC 20036, within 20 days of receipt of the decision. The department may assist with the appeal upon request.

b. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can

demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery day.

c. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review provided in Iowa Code chapter 17A or as described in 441—Chapter 7.

441—93.16(239B) Resolution of a limited benefit plan.

93.16(1) Resolution process for a first limited benefit plan. For participants who choose a first limited benefit plan, the notice of decision shall inform the participant of the action needed to reconsider the limited benefit plan as described at 441—subparagraph 41.24(8) “d”(1).

a. The notice of decision establishing a first limited benefit plan shall inform the FIP participant that the participant may reconsider at any time from the date timely and adequate notice is issued establishing the limited benefit plan. The notice of decision shall inform the participant that the participant shall contact the department or appropriate PROMISE JOBS office to reconsider the limited benefit plan.

b. When the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to begin or resume development of the FIA as described elsewhere in these rules.

c. When the FIA is signed, the PROMISE JOBS worker shall notify the department and the limited benefit plan shall be terminated. FIP benefits shall be effective as described at 441—subparagraph 41.24(8) “d”(1).

93.16(2) Resolution process for a subsequent limited benefit plan. The notice of decision establishing a subsequent limited benefit plan shall inform the FIP participant of the six-month ineligibility period and that the participant may reconsider at any time following the six-month ineligibility period. To reconsider, the participant must complete significant contact with or action in regard to the PROMISE JOBS program as described at 441—subparagraph 41.24(8) “d”(3).

a. When the six-month ineligibility period ends and the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to sign a new or updated FIA and to begin significant action as described at 441—subparagraph 41.24(8) “d”(3).

b. When the FIA is signed and the participant has satisfactorily completed the significant action, the PROMISE JOBS worker shall notify the department and the limited benefit plan shall be terminated. FIP benefits shall be effective as described at 441—subparagraph 41.24(8) “d”(3).

441—93.17(239B) Worker displacement grievance procedure. The PROMISE JOBS program shall provide a grievance procedure to address and resolve public complaints regarding the displacement of regular workers with program participants in a work experience placement.

93.17(1) The procedure shall provide that:

a. Complaints must be filed in writing and received by the PROMISE JOBS service provider within one year of the alleged violation.

b. A representative of the PROMISE JOBS service provider must schedule a face-to-face interview with the complainant within 7 days of the date the complaint is filed, to provide the opportunity for informal resolution of the complaint.

c. Written notice of the location, date and time of the face-to-face interview must be provided.

d. An opportunity must be provided to present evidence at the face-to-face interview.

e. The representative of the PROMISE JOBS service provider shall issue a decision in writing within 14 days of the date a complaint is filed.

f. A written explanation must be provided to all involved parties of the right to file a written appeal, according to 441—Chapter 7, if the opportunity for informal resolution is declined, if a party receives an adverse decision from the PROMISE JOBS service provider, or if there is no decision within the 14-day period.

(1) To be considered, an appeal must be filed with the department within 10 days of the mailing date of the adverse decision or within 24 days of the date a complaint is filed

(2) An appeal hearing will not be granted until informal resolution procedures have been exhausted, unless a decision has not been issued within 24 days of the complaint filing date.

93.17(2) The department shall issue a final decision within 90 days of the date the complaint was filed with the PROMISE JOBS service provider.

93.17(3) Any dissatisfied party shall be informed of the right to appeal the decision of the department to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, Vanguard Building, Room 600, 111 20th Street N.W., Washington, DC 20036, within 20 days of the receipt of the department's final decision.

a. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery date.

b. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review as provided in Iowa Code chapter 17A or as described in 441—Chapter 7.

93.17(4) Upon notice of a complaint or grievance, the PROMISE JOBS office must provide the complaining party with a copy of the grievance procedures, notification of the right to file a formal complaint and instruction on how to file a complaint.

93.17(5) Upon filing a complaint, and at each stage thereafter, each complainant must be notified in writing of the next step in the complaint procedure.

93.17(6) The identity of any person who has furnished information relating to, or assisting in, an investigation of a possible violation must be kept confidential to the extent possible, consistent with due process and a fair determination of the issues.

93.17(7) All employers who participate in the PROMISE JOBS program shall provide assurances that all regular employees are aware of this grievance procedure.

These rules are intended to implement Iowa Code section 239B.17 to 239B.22.

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CHAPTER 106
CERTIFICATION STANDARDS FOR CHILDREN'S RESIDENTIAL FACILITIES

PREAMBLE

It is the policy of this state to provide appropriate protection for children who are separated from the direct personal care of their parents, relatives, or guardians. Therefore, the intent of this chapter is to establish certification standards for facilities that meet the definition of "children's residential facility" pursuant to Iowa Code chapter 237C. Iowa Code chapter 237C requires the department to establish standards that shall, at a minimum, address the basic health and educational needs of children; protection of children from mistreatment, abuse, and neglect; background and records checks of persons providing care to children in facilities certified under this chapter; the use of seclusion, restraint, or other restrictive interventions; health; safety; emergency; and the physical premises on which care is provided by a children's residential facility.

Iowa Code chapter 237C specifies that the standards established by the department shall not regulate religious education curricula at children's residential facilities.

These rules cover definitions, application of the standards, the certification process, and provisions to address basic needs; educational programs and services; protection of children from mistreatment, abuse, and neglect; discipline; background and records checks of persons providing care to children in facilities certified under this chapter; the use of seclusion, restraint, or other restrictive interventions; health; safety; emergencies; the physical premises where care is provided by a children's residential facility; sanitation, water, and waste disposal; staffing; and reports and inspections.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.1(237C) Definitions.

"Administrator" means the administrator of that division of the department designated by the director of human services to administer this chapter or the administrator's designee.

"Agency," unless otherwise provided by law, means an individual, corporation, limited liability company, business trust, estate, trust, partnership or association, or any other legal entity which provides care as a children's residential facility.

"Chemical restraint" means the use of chemical agents, including psychotropic drugs, as a form of restraint.

"Child" or *"children"* means an individual or individuals less than 18 years of age.

"Children's residential facility" means a private facility designed to serve children who have been voluntarily placed for reasons other than an exclusively recreational activity outside of their home by a parent or legal guardian and who are not under the custody or authority of the department of human services, juvenile court, or another governmental agency, that provides 24-hour care, including food, lodging, supervision, education, or other care on a full-time basis by a person other than a relative or guardian of the child, but does not include an entity providing any of the following:

1. Care furnished by an individual who receives the child of a personal friend as an occasional and personal guest in the individual's home, free of charge and not as a business.
2. Care furnished by an individual with whom a child has been placed for lawful adoption, unless that adoption is not completed within two years after placement.
3. Child care furnished by a child care facility as defined in Iowa Code section 237A.1.
4. Care furnished in a hospital licensed under Iowa Code chapter 135B or care furnished in a health care facility as defined in Iowa Code section 135C.1.
5. Care furnished by a juvenile detention home or juvenile shelter care home approved under Iowa Code section 232.142.
6. Care furnished by a child foster care facility licensed under Iowa Code chapter 237.
7. Care furnished by an institution listed in Iowa Code section 218.1.
8. Care furnished by a facility licensed under Iowa Code chapter 125.
9. Care furnished by a psychiatric medical institution for children licensed under Iowa Code chapter 135H.

“*Control room*” means a locked room used for treatment purposes.

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

“*Mechanical restraint*” means restriction of a child’s mobility or ability to use the child’s hands, arms, or legs by the use of a mechanical device.

“*Physical restraint*” means direct physical contact required on the part of a staff member to prevent a child from hurting self, others, or property.

“*Prone restraint*” means a physical restraint in which a child is held face down on the floor.

“*Staff*” means any person providing care or services to or on behalf of the facility whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.2(237C) Application of the standards. These rules shall apply to all facilities that meet the definition of “children’s residential facility” pursuant to Iowa Code chapter 237C. In the event that a children’s residential facility is also subject to licensure, certification, registration, or regulation pursuant to another provision of law, those legal requirements shall take precedence over these rules.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.3(237C) Application for a certificate of approval. A person shall not operate a children’s residential facility without a certificate of approval to operate issued by the administrator.

106.3(1) Right to apply.

a. Any adult individual or agency may apply for a certificate of approval.

b. Parties wishing to apply for certification as a children’s residential facility shall contact the department using the department’s website or by contacting the Iowa Department of Human Services, Division of Adult, Children and Family Services, Attn: children’s residential facility certification, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

106.3(2) Application. An applicant shall complete Form 470-0723, Application for License or Certificate of Approval.

106.3(3) Withdrawal of an application. The applicant shall report the withdrawal of an application promptly to the department.

106.3(4) Evaluation of the application. Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded abuse report on a director, a sole proprietor involved in the facility’s operation, or any facility staff shall be evaluated by the department to determine if the abuse merits prohibition of employment, volunteer work, or certification.

b. The department shall evaluate all founded child abuse on a case-by-case basis. Considerations shall include, but not be limited to:

(1) The applicant’s or certified entity’s response (e.g., immediate termination of involved staff).

(2) Whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

106.3(5) Reports and information. The applicant shall furnish requested reports and information relevant to the certification determination to the department.

106.3(6) Applications for renewal of certificate of approval.

a. The department or its agent shall send the certificate of approval holder an application for renewal 90 days before the certificate expires. Applications for certificate renewal shall be made on the form specified in subrule 106.3(2).

b. Applications for certificate renewal shall be made at least 30 days but no more than 90 days before the certificate of approval expires. Applications for renewal of a children’s residential facility certificate of approval shall be submitted to the address listed in paragraph 106.3(1)“*b.*”

106.3(7) Notification. The department shall notify a children’s residential facility of approval or denial of a certificate within 90 days of the department’s receipt of complete application or reapplication information.

106.3(8) Fire inspection.

a. Before the administrator issues or reissues a certificate of approval to a children's residential facility, the facility shall comply with standards adopted by the state fire marshal under Iowa Code chapter 100.

b. Each children's residential facility shall procure an annual fire inspection approved by the state fire marshal and shall meet the recommendations thereof.

c. In the case of a conflict between rules and standards adopted pursuant to this chapter and local rules and standards, the more stringent requirement applies.

This rule is intended to implement Iowa Code sections 237C.4 and 237C.6.
[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.4(237C) Certificate of approval.

106.4(1) A new certificate of approval shall be obtained when the certified location moves or the facility is remodeled.

106.4(2) The certificate of approval shall state on its face the name of the holder of the certificate, the particular premises for which the certificate is issued, and the number of children who may be cared for by the children's residential facility on the premises at one time under the certificate of occupancy issued by the state fire marshal or the state fire marshal's designee. The certificate of approval shall be posted in a conspicuous place in the children's residential facility.

106.4(3) A children's residential facility shall operate only in a building or on premises designated in the certificate of approval.

106.4(4) A new certificate of approval shall be requested when the children's residential facility wishes to be certified for a different number of children.

106.4(5) The department shall issue Form 470-0620, Certificate of Approval, without cost to any children's residential facility that meets the standards. The department may offer consultation to assist applicants in meeting the standards.

106.4(6) Children's residential facilities shall be certified for a term of one year.

This rule is intended to implement Iowa Code sections 237C.6 and 237C.7.
[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.5(237C) Denial, suspension, or revocation.

106.5(1) The administrator may deny an application for issuance or reissuance of a certificate of approval if:

a. The applicant or certificate holder, as applicable, fails to comply with these rules or knowingly makes a false statement concerning a material fact or conceals a material fact on the application for the issuance or reissuance of a certificate of approval or in a report regarding operation of the children's residential facility submitted to the administrator.

b. The applicant or any person residing in the children's residential facility or any facility staff has a record of founded child abuse unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment, volunteer work, or certification.

106.5(2) The administrator may suspend a certificate of approval if:

a. The applicant or certificate holder, as applicable, fails to comply with these rules or knowingly makes a false statement concerning a material fact or conceals a material fact on the application for the issuance or reissuance of a certificate of approval or in a report regarding operation of the children's residential facility submitted to the administrator.

b. A children's residential facility's failure to meet the certification requirements poses a danger to the health, safety, or well-being of the children being served.

c. A children's residential facility fails to comply with Iowa Code section 282.34.

106.5(3) All operations of a children's residential facility shall cease during a period of suspension or revocation of a certificate of approval, including during an appeal. A suspension of a certificate of approval shall not extend beyond six months, and the existence of the condition requiring suspension shall be corrected within six months and documented in the record of the holder of the certificate of approval.

106.5(4) Effective period of suspension. A suspension shall be effective on the date the notice is received by the holder of the certificate of approval and shall remain in effect until one of the following occurs:

- a. The department withdraws the suspension due to a change in conditions in the children's residential facility.
- b. The court orders the certificate of approval reinstated.
- c. The action is reversed by a final decision in accordance with 441—Chapter 7.
- d. The certification period expires.

106.5(5) Method and content of notice. The notice of suspension shall be sent by restricted certified mail or personal service and shall include the following:

- a. The condition requiring the suspension.
- b. The specific law or rule violated.

106.5(6) The administrator may revoke a certificate of approval if:

a. The applicant or certificate holder, as applicable, fails to comply with these rules or knowingly makes a false statement concerning a material fact or conceals a material fact on the application for the issuance or reissuance of a certificate of approval or in a report regarding operation of the children's residential facility submitted to the administrator.

b. The conditions requiring suspension are not corrected within six months.

c. A children's residential facility fails to comply with Iowa Code section 282.34.

106.5(7) Right to appeal suspension or revocation. The holder of the certificate of approval has the right to appeal a suspension or revocation of the certificate of approval, but initiation of an appeal does not alter the suspension or revocation. Notices of adverse actions and the right to appeal shall be given to applicants and certificate of approval holders in accordance with 441—Chapter 7 and rule 441—16.3(17A).

106.5(8) Corrective action. The facility shall furnish the department with a plan of action to correct deficiencies that resulted in the suspension or revocation of a certificate of approval. The plan shall give specific dates upon which the corrective action will be completed.

This rule is intended to implement Iowa Code section 237C.6.

[ARC 3007C, IAB 3/29/17, effective 5/3/17; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—106.6(237C) Providing for basic needs.

106.6(1) A children's residential facility shall provide the following for children in its care:

- a. Adequate shelter.
- b. Nourishing food and water.
- c. Opportunities for adequate sleep, exercise, cleanliness, and health maintenance.

106.6(2) A children's residential facility shares responsibility for meeting these basic needs with the children's parents, guardians, or other primary caretakers.

106.6(3) A children's residential facility shall have written policies related to:

a. Children's communication with their parents or guardians.

b. Children's ability to receive visitors who have been approved by their parents or guardians.

c. Confidentiality and reasonable privacy for children. The children's residential facility shall afford children and their families privacy and confidentiality unless doing so would jeopardize a child's health or safety.

d. Children's ability to keep personal belongings such as clothing, pictures, and other items.

e. Children's ability to participate in normal community activities.

106.6(4) A children's residential facility shall not impose rules and restrictions that prevent communication with parents, guardians, other family members, or others.

106.6(5) A children's residential facility shall share its written policies related to communication, visitors, personal belongings, and participation in community activities with a child's parents or guardians before a child is admitted to the children's residential facility.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.7(237C) Educational programs and services. A children's residential facility operating under a certificate of approval issued under Iowa Code chapter 237C shall comply with rules adopted by the state board of education pursuant to Iowa Code section 282.34.
[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.8(237C) Protection from mistreatment, physical abuse, sexual abuse, and neglect.

106.8(1) The state of Iowa prohibits child abuse as defined in Iowa Code chapter 232, criminal assault, and other criminal acts of violence. A children's residential facility shall not use discipline that amounts to child abuse or a criminal act of assault or violence.

106.8(2) A children's residential facility's written policies shall:

- a. Prohibit mistreatment, physical abuse, sexual abuse, and neglect of children.
- b. Specify reporting and enforcement procedures for the children's residential facility. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel.
- c. Prohibit the use of corporal punishment. The facility's policies shall clearly prohibit staff or the children from utilizing corporal punishment as a method of discipline or correcting children.
- d. These policies shall be communicated in writing to all staff of the facility.

This rule is intended to implement Iowa Code section 237C.3.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.9(237C) Discipline.

106.9(1) Generally. The facility shall have written policies, which shall be available to all staff and to the child's family, regarding methods used for control and discipline of children. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep.

106.9(2) Corporal punishment is prohibited. The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy is to be communicated in writing to all staff of the facility.

106.9(3) The administration of discipline by a child to another child is prohibited.

106.9(4) Behavior expectations. The facility shall make available to the child and the child's parents or guardian written policies regarding the following areas:

- a. The general expectation of behavior, including the facility's rules and practices.
- b. The range of reasonable consequences that may be used to deal with inappropriate behavior.

106.9(5) Discipline policies shall be discussed with:

- a. Staff, volunteers, or others who perform duties under a subcontract with the children's residential facility; and
- b. Parents or guardians before children are admitted to the children's residential facility.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.10(237C) Record checks.

106.10(1) A children's residential facility shall conduct record checks for:

a. Any owner, director, staff member, volunteer, or other person who performs duties under a subcontract with the children's residential facility and who:

- (1) Has direct responsibility for children, or
 - (2) Has access to a child when the child is alone.
- b. Anyone living in the children's residential facility who is 14 years of age or older.

106.10(2) The record checks shall be conducted to determine whether the person:

- a. Has any founded child abuse reports.
- b. Has any founded dependent adult abuse reports.
- c. Has any criminal convictions.
- d. Has been placed on the sex offender registry.

106.10(3) Every applicant for employment shall submit to the children's residential facility a written, signed and dated statement that discloses:

- a. Any substantiated instances of child abuse, neglect, or sexual abuse committed by the person.
- b. Any substantiated instances of dependent adult abuse committed by the person.
- c. Any convictions of crimes involving the mistreatment or exploitation of a child.

106.10(4) A children's residential facility may request additional information from the central abuse registry or the Iowa department of public safety.

106.10(5) If a record of criminal conviction or founded child abuse or founded dependent adult abuse exists, the children's residential facility shall evaluate the crime or founded child abuse or dependent adult abuse to determine whether or not the crime or founded child abuse or founded dependent adult abuse merits prohibition of employment or any voluntary or subcontracted position. The evaluation shall consider:

- a. The nature and seriousness of the crime or founded abuse in relation to the position sought,
- b. The time elapsed since the commission of the crime or founded abuse,
- c. The circumstances under which the crime or founded abuse was committed,
- d. The degree of rehabilitation,
- e. The number of crimes or founded abuses committed by the person involved, and
- f. The likelihood that the person will commit the crime or founded abuse again.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.11(237C) Seclusion and restraints.

106.11(1) A children's residential facility shall not physically restrain a child unless necessary to prevent the child from hurting self, others, or property. Physical restraint must be conducted in a standing position whenever possible. Prone restraint is prohibited.

- a. No staff person shall use any restraint that obstructs the airway of a child.
- b. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.
- c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.
- d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly set forth in the child's record by the responsible staff persons.

106.11(2) A children's residential facility shall not put a child into time-out seclusion for more than one hour. A child shall never be secluded in an area that is locked or out of the view of staff, volunteers, or others who perform duties under a subcontract with the children's residential facility.

106.11(3) At no time shall a children's residential facility use a control room, mechanical restraint, or chemical restraint.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.12(237C) Health.

106.12(1) A children's residential facility shall obtain, store, prepare, and serve food and water free from contamination.

106.12(2) A children's residential facility shall have written health policies that describe how the facility will care for a sick child residing there.

106.12(3) A children's residential facility shall have written policies and procedures related to disease control and the use of universal precautions for handling of any bodily excrement or discharge, including blood and breast milk. A children's residential facility shall take precautions to prevent the spread of infectious and communicable disease.

106.12(4) A children's residential facility shall seek immediate medical attention for a child when it is necessary to ensure that the child remains healthy. There shall be 24-hour emergency and routine medical and dental services available and provided when prescribed. Provision of these services shall be documented.

106.12(5) A children's residential facility shall have written policies and procedures to ensure that staff, volunteers, or others who perform duties under a subcontract with the children's residential facility demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease and are certified in the provision of first aid and cardiopulmonary resuscitation.

106.12(6) A children's residential facility shall be required to report any reportable disease to the department of public health.

106.12(7) A children's residential facility shall have written policies on physical examination reports or health status statements for all children in the facility's care.

106.12(8) A children's residential facility shall have written policies and procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications.

106.12(9) A children's residential facility shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff, volunteers, or others who perform duties under a subcontract with the children's residential facility at all times when children are in the facility, in the outdoor play area, and on field trips. The first-aid kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

106.12(10) A children's residential facility shall have written policies on reporting illness or injury to parents or guardians. These policies shall be shared with parents or guardians before a child is admitted to the children's residential facility. A significant change in health status or incidents resulting in a serious injury to or death of a child shall be reported immediately to the parent or guardian.

106.12(11) A children's residential facility shall have written policies on smoking and tobacco use that comply with Iowa state law.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.13(237C) Safety.

106.13(1) A children's residential facility shall provide a sufficient number of staff to ensure safe practices that are based on the ages and needs of the children in care to ensure adequate supervision and child safety. This requirement applies to daytime and overnight hours.

106.13(2) Poison control centers' telephone numbers shall be posted in prominent locations and readily available. All poisonous or caustic drugs or materials shall:

- a. Be plainly labeled.
- b. Be stored separately from other drugs in a specific, well-illuminated cabinet, closet, or storeroom.
- c. Be stored in a manner that prevents accidental or intentional ingestion.
- d. Be accessible only to authorized persons.

106.13(3) A children's residential facility shall have written policies regarding fishing ponds, lakes, or any bodies of water located on or near the facility's grounds and accessible to children.

- a. All swimming pools shall conform to state and local health and safety regulations.
- b. Adult supervision shall be provided at all times when children are near or in the water.

106.13(4) A children's residential facility shall have written policies regarding transportation of a child that ensure compliance with Iowa Code section 321.446 regarding child restraint devices.

- a. Drivers of vehicles shall possess a valid driver's license.
- b. Drivers shall not operate a vehicle while under the influence of alcohol, illegal drugs, or prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.
- c. All vehicles used for children's residential facility activities shall be maintained in safe operating condition.
- d. A children's residential facility shall have proof of current insurance that covers all vehicles and drivers used to transport children.

106.13(5) Animals kept on site shall:

- a. Be in good health with no evidence of disease.
- b. Be of such disposition as to not pose a safety threat to any person.
- c. Be maintained in a clean and sanitary manner.

106.13(6) Weapons and ammunition are prohibited on the premises of a children's residential facility.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.14(237C) Emergencies.

106.14(1) A children's residential facility shall have written emergency plans for responding to evacuations, fires, tornadoes, floods, blizzards, other weather incidents, power failures, bomb threats, chemical spills, earthquakes, or other natural or man-made disasters that could create structural damage to the children's residential facility or pose health or safety hazards.

a. The emergency plans shall include guidelines for responding to situations involving intruders within the children's residential facility and grounds, intoxicated persons, lost or abducted children, and evacuations.

b. Emergency plans shall be coordinated with county emergency planning agencies.

c. Evacuations and how to seek protective shelter shall be practiced periodically.

106.14(2) The emergency plans shall include procedures for annual training regarding the contents and implementation of the plans for staff, volunteers, or others who perform duties under a subcontract with the children's residential facility.

106.14(3) A children's residential facility shall have:

a. Written policies and procedures for medical and dental emergencies.

b. Sufficient information and authorization to meet the medical and dental needs or emergencies of children.

106.14(4) Emergency telephone numbers shall be readily available, including emergency telephone numbers for parents or guardians.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.15(237C) Buildings and physical premises. A children's residential facility shall ensure that the facility and grounds, playground surfaces and other areas, and all related equipment are safe and free from hazards.

106.15(1) A children's residential facility shall comply with requirements established by the fire marshal for the applicable type of occupancy and shall comply with any applicable additional fire safety requirements established by local ordinance, including fire inspections.

106.15(2) A children's residential facility shall be structurally sound. Any new facility or existing facility that is extensively renovated shall be constructed in compliance with applicable requirements of the state of Iowa building code established pursuant to Iowa Code chapter 103A and with any local building code in force at the time of construction.

106.15(3) A children's residential facility located in a building built before 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint.

a. 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 the paint is not lead-based.

b. In the absence of the determination that peeling or chipping paint is not lead-based, a children's residential facility shall use safe work methods as defined by the state department of public health to eliminate human exposure or likely exposure to lead-based paint hazards.

106.15(4) Living areas.

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceiling surfaced with materials that are asbestos-free.

b. All sleeping rooms shall:

- (1) Provide a minimum of 60 square feet per child for multiple occupancy.
- (2) Provide a minimum of 80 square feet per child for single occupancy.
- (3) Not sleep more than four children per room.
- (4) Be of finished construction.
 - c. Rooms aboveground shall:
 - (1) Have a ceiling height of at least 7 feet, 6 inches.
 - (2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.
 - d. Rooms belowground shall:
 - (1) Have a ceiling height of at least 6 feet, 8 inches.
 - (2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.
 - (3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

106.15(5) Bedrooms.

- a. Each child in care shall have a solidly constructed bed.
- b. Sheets, pillowcases, and blankets shall be provided for each child and shall be kept clean and in good repair.
- c. Each child in care shall have adequate storage space for private use and a designated space for hanging clothing in proximity to the bedroom occupied by the child.
- d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

106.15(6) Heating.

- a. The heating unit shall be located and operated to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.
- b. All space heaters and water heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be vented to the outside atmosphere.
- c. Neither rubber nor plastic tubing shall be used as supply lines for gas heaters.
- d. The heating or cooling plant shall be checked at least annually and kept in safe working condition at all times.

These rules are intended to implement Iowa Code section 237C.3.
 [ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.16(237C) Sanitation, water, and waste disposal. In the case of a conflict between rules and standards adopted pursuant to this chapter and local rules and standards, the more stringent requirement applies.

106.16(1) Bathroom facilities.

- a. Bathrooms shall have an adequate supply of hot and cold running water.
- b. Each bathroom shall be properly equipped with toilet tissue, towels, soap, and other items required for personal hygiene unless children are individually given these items. Paper towels, when used, and toilet tissue shall be in dispensers.
- c. Toilets and baths or showers shall provide for individual privacy.
- d. There shall be a shower or tub for each ten children or portion thereof.
- e. Tubs and showers shall have slip-proof surfaces.
- f. At least one toilet and one lavatory shall be provided for each six children or portion thereof.
- g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.
- h. Toilet facilities adjacent to a food preparation area shall be separated completely by an enclosed solid door.
- i. All toilet facilities shall be kept clean.
- j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

106.16(2) Food preparation and storage.

- a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.
- b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.
- c. Storage areas for frozen foods shall be kept at 0 degrees Fahrenheit or below.
- d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.
- e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or below.
- f. The kitchen and food storage areas shall be kept clean and neat. Foods shall not be stored on the floor.
- g. The floor and walls shall be of smooth construction and in good repair.

106.16(3) Personnel handling food. Personnel who handle food shall:

- a. Be free of infection.
- b. Be clean and neatly groomed.
- c. Wear clean clothes.
- d. Not use tobacco in any form while preparing or serving food.

106.16(4) Dishwashing facilities.

- a. Manual dishwashing will be allowed in facilities that normally serve 15 or fewer people at one meal.
- b. Commercial dishwashers shall be used in facilities serving more than 15 people at one meal and shall meet the following criteria:
 - (1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.
 - (2) Machines using hot water for sanitizing must maintain wash water at a temperature of at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.
 - (3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.
- c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.
- d. All handheld food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns, and similar equipment shall be cleaned and sanitized daily.

106.16(5) Foods not prepared at site of serving.

- a. The place where food is prepared for off-site serving shall conform to all requirements for on-site food preparation.
- b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.
- c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food shall be maintained at 45 degrees Fahrenheit or below.

106.16(6) Milk supply. When fluid milk is used, it shall be pasteurized Grade A.

106.16(7) Public water supply. The water supply is approved when the water is obtained from a public water supply system, as regulated by the department of natural resources.

106.16(8) Private water supplies. Any facility that serves at least 25 people for at least 60 days during the year and is supplied by its own well meets the definition of a public water supply and must be regulated by the department of natural resources.

a. Each privately operated water supply shall be maintained and operated in a manner that ensures safe drinking water. Each water supply used as part of a facility shall be annually inspected and evaluated for deficiencies that may allow contaminants access to the well interior. Items such as open or loose well caps, missing or defective well vents, poor drainage around the wells, and the nearby storage of potential contaminants shall be evaluated. All deficiencies shall be corrected within 30 days of discovery by a well contractor certified by the state.

b. Evaluation and water testing. As part of the inspection and evaluation, water samples shall be collected and submitted by the local health sanitarian or a well contractor certified by the state to the

state hygienic laboratory or other laboratory certified for drinking water analysis by the department of natural resources. The minimum yearly water analysis shall include coliform bacteria and nitrate (NO₃-) content. Total arsenic testing shall be performed once every three years. The water shall be deemed safe when there are no detectible coliform bacteria, when nitrate levels are less than 10 mg/L as nitrogen, and when total arsenic levels are 10 µg/L or less. A copy of the laboratory analysis report shall be provided to the department within 72 hours of receipt by the water supply.

c. Multiple wells supplying water. When the water supply obtains water from more than one well, each well connected to the water distribution system shall meet all of the requirements of these rules.

d. Deficiencies. When no apparent deficiencies exist with the well or its operations and the water supply is proven safe by meeting the minimum sampling and analysis requirements, water safety requirements have been met. Wells with deficiencies that result in unsafe water analysis require corrective actions through the use of a well contractor certified by the state.

e. When water is proven unsafe. When the water supply is proven unsafe by sampling and analysis, the facility shall immediately provide a known source of safe drinking water for all water users and hang notification at each point of water use disclosing the water is not safe to consume. In addition, the facility shall provide a written statement to the department disclosing the unsafe result and detail a plan on how the water supply deficiencies will be corrected and the supply brought back into a safe and maintained condition. The statement shall be submitted to the department within 10 days of the laboratory notice. All corrective work shall be performed and the water supply sampled and analyzed again within 45 days from any water test analysis report that indicates the water supply is unsafe for drinking water uses.

f. Water obtained from another source through hauling and storage must meet the requirements of the department of natural resources.

106.16(9) Heating or storage of hot water. Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

106.16(10) Sewage treatment.

a. A children's residential facility shall be connected to a public sewer system where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

106.16(11) Garbage storage and disposal.

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be insect-, rodent-, and leakproof and shall be maintained in a sanitary condition.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.17(237C) Staffing.

106.17(1) Children's residential facility staff shall be 21 years of age or older with appropriate training and experience related to job duties.

106.17(2) A children's residential facility shall have written policies and procedures regarding staff supervision, development, training requirements, and orientation to children's residential facility policies and practices.

106.17(3) A children's residential facility shall provide a sufficient number of staff to ensure proper supervision and child safety at all times and at all activities conducted by a children's residential facility off its premises.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.18(237C) Reports and inspections.

106.18(1) The administrator may require submission of reports by a certificate of approval holder and shall cause at least one annual unannounced inspection of a children's residential facility to assess compliance with applicable requirements and standards.

106.18(2) The inspections shall be conducted by the department of inspections and appeals in addition to initial, renewal, and other inspections that result from complaints or self-reported incidents.

106.18(3) The department of inspections and appeals and the department of human services may examine records of a children's residential facility and may inquire into matters concerning the children's residential facility and its employees, volunteers, and subcontractors relating to requirements and standards for children's residential facilities under this chapter.

[ARC 3007C, IAB 3/29/17, effective 5/3/17]

441—106.19(232) Mandatory reporting of child abuse.

106.19(1) *Mandatory reporters.* Any employee, operator, owner, or other person who performs duties for a children's residential facility shall make a report, in accordance with Iowa Code section 232.69, whenever that person reasonably believes a child for whom the person is providing care has suffered abuse.

106.19(2) *Required training.* Staff shall receive training relating to the identification and reporting of child abuse as required by Iowa Code section 232.69.

106.19(3) *Training documentation.* The certified children's residential facility shall develop and maintain a written record for each employee, operator, owner, or other person who performs duties for the children's residential facility in order to document the content and amount of training.

This rule is intended to implement Iowa Code section 232.69.

[ARC 4113C, IAB 11/7/18, effective 1/1/19]

These rules are intended to implement Iowa Code chapter 237C.

[Filed ARC 8009B (Notice ARC 7769B, IAB 5/20/09), IAB 7/29/09, effective 9/2/09]

[Filed ARC 3007C (Notice ARC 2918C, IAB 2/1/17), IAB 3/29/17, effective 5/3/17]

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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 child’s 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 for children who are attending prekindergarten as defined by the state board of education under Iowa Code section 256.11 or a higher grade level and are at least four years of age, or at least three years of age and eligible for special education under Iowa Code chapter 256B, and administered by a public or nonpublic school system accredited by the department of education or the state board of regents or a nonpublic school system which is not accredited by the department of education or the state board of regents.
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 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.
7. 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.
8. 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.

9. A nationally accredited camp.

10. 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.

11. Care provided on site to children of parents residing in an emergency, homeless, or domestic violence shelter.

12. 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.

13. 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; ARC 2169C, IAB 9/30/15, effective 1/1/16; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3555C, IAB 1/3/18, effective 3/1/18]

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 a department-provided application for a license to operate a child care center.

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 is considered appropriate for use by a child care facility.

c. When a center makes a sufficient application for an initial license, the center may operate for a period of up to 120 calendar days from the date of issuance of the form granting permission to open without a license, pending a final licensing decision. A center has made a sufficient application when it has had an on-site visit and 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 submit the regulatory fee as specified in subrule 109.2(7) to the department’s division of fiscal management.

e. 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 a form granting 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 the form.

(2) No full or provisional license shall be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(7).

f. 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.

g. 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 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 complies with 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 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 within 60 calendar days from the due date on the 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 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 and rule 441—16.3(17A).

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. A fee based upon center capacity is due to the department at the time of 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 the child care center licensing fee invoice to the center.

d. Payment. The center shall return the child care center licensing fee invoice to the department with the licensing fee payment within 60 calendar days from the date on the invoice. Payment may be in the form of cash, check, money order, or cashier's check. 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; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 4752C, IAB 11/6/19, effective 12/11/19; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—109.3(237A) Inspection and evaluation. The department shall conduct an unannounced 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.
[ARC 4752C, IAB 11/6/19, effective 12/11/19]

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.

i. Develop and implement a policy for protection of each child's confidentiality.

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 decision 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 “Child Care Centers and Preschools Licensing Standards and Procedures” shall be available in the child care 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; ARC 2646C, IAB 8/3/16, effective 10/1/16]

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. 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.

[ARC 2646C, IAB 8/3/16, effective 10/1/16]

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 or higher 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 or higher 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. Rescinded IAB 8/3/16, effective 10/1/16.

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 \$35 for each record check. 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. 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 prior to a person's involvement with child care 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.

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) A requirement to be listed on any state sex offender registry or the national sex offender registry.

- (3) Any of the following felony convictions:

1. Child endangerment or neglect or abandonment of a dependent person.

2. Domestic abuse.

3. Crime against a child including, but not limited to, sexual exploitation of a minor.

4. Forcible felony.

5. Arson.

- (4) A record of a misdemeanor conviction of a crime against a child that constitutes one of the following offenses:

1. Child abuse.

2. Child endangerment.

3. Sexual assault.

4. Child pornography.

(5) If a person subject to a record check refuses to consent to a record check, the person shall be prohibited from involvement with child care.

(6) If a person has been convicted of a crime and makes what the person knows to be a false statement of material fact in connection with the conviction or record check, the person shall be prohibited from involvement with child care.

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.

(5) The department shall reevaluate any transgressions where a state or federal law change requires different considerations of the transgression than had been previously applied.

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; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 4114C, IAB 11/7/18, effective 1/1/19]

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 three months of employment. During their first three 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.
c. Certification in American Red Cross, American Heart Association, American Safety and Health Institute, or MEDIC First Aid 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. 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, the American Safety and Health Institute, or 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.

e. Minimum health and safety trainings, approved by the department, in the following areas:

- (1) Prevention and control of infectious disease, including immunizations.
- (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
- (3) Administration of medication, consistent with standards for parental consent.

- (4) Prevention of and response to emergencies due to food and allergic reactions.
- (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- (6) Prevention of shaken baby syndrome and abusive head trauma.
- (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- (9) Precautions in transporting children.
- (10) Child development, on or after August 1, 2017.

Minimum health and safety training may be required if content has significant changes which warrant that the training be renewed.

109.7(2) Center directors and all staff.

a. During their first year of employment, all center directors and all staff shall receive the following training:

- (1) 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.
- (2) 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.
- (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 first year's ten contact hours of training waived.

b. Following their first year of employment, all center directors and all staff 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"(1). 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"(1).
- c. Initial training obtained as identified in paragraph 109.7(1)"e" may be counted toward annual training hours during the year of employment in which the training is taken.
- d. Training identified in paragraph 109.7(1)"e" shall not count towards annual professional development more than once.

109.7(3) Staff employed in centers that operate summer-only programs. During their first three 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.
- c. Certification in American Red Cross, American Heart Association, American Safety and Health Institute, or MEDIC First Aid 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. 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, the American Safety and Health Institute, or 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.

e. Minimum health and safety trainings, approved by the department, in the following areas:

- (1) Prevention and control of infectious disease, including immunizations.
- (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
- (3) Administration of medication, consistent with standards for parental consent.
- (4) Prevention of and response to emergencies due to food and allergic reactions.
- (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- (6) Prevention of shaken baby syndrome and abusive head trauma.
- (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- (9) Precautions in transporting children.
- (10) Child development, on or after August 1, 2017.

109.7(4) *Training plans.* Training shall supplement the 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(5) *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(6) *Approved training.*

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.
- (14) Organizations that are certified by the International Association for Continuing Education and Training (IACET).

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(7);
- (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 for review to the department a 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(7) *Elements of 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.

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.

109.7(8) *Training for supervisors and designees.* The director, on-site supervisor, and any person designated a lead in the absence of supervisory staff shall have completed all preservice/orientation training outlined in subrule 109.7(1).

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17; ARC 4753C, IAB 11/6/19, effective 12/11/19]

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 or fewer children, provided no more than two of the children are under the age of two years and there are no more than six children in the center.

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.

[ARC 2646C, IAB 8/3/16, effective 10/1/16]

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 a DHS criminal history record check form 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 a request for child abuse information form, 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.

g. For any child with allergies, a written emergency plan is available in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.

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; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

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.

d. A child care staff member shall not provide medications to a child if the staff member has not completed preservice/orientation training that includes medication administration.

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.*

a. 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.

b. Incidents resulting in a serious injury, as defined in Iowa Code section 702.18, to a child in the child care facility or in the care of child care facility staff 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.

(1) Serious injuries shall be reported to the department within 24 hours of the incident.

(2) Serious injuries shall be documented and information maintained in the child's file as required by subrule 109.9(2).

c. 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).

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 and diagrams for responding to fire, tornado, and flood (if area is susceptible to flood), and plans for responding to 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 the following:

- (1) Evacuation to safely leave the facility.
 - (2) Relocation to a common, safe location after evacuation.
 - (3) Shelter-in-place to take immediate shelter when the current location is unsafe to leave due to the emergency issue.
 - (4) Lockdown to protect children and providers from an external situation.
 - (5) Communication and reunification with parents or other adults responsible for the children which shall include emergency telephone numbers.
 - (6) Continuity of operations.
 - (7) To address the needs of individual children, including those with functional or access needs.
- 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 and volunteer 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 and volunteers.

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; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17; ARC 3096C, IAB 6/7/17, effective 8/1/17]

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. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Requirements are as follows:

(1) Infants shall always be placed on their backs for sleep.

(2) Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission federal standards.

(3) Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for sleeping including, but not limited to, an infant seat, car seat, swing, or bouncy seat.

(4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

(5) No co-sleeping shall be allowed.

(6) Sleeping infants shall be actively observed by sight and sound.

(7) If an alternate sleeping position is needed, a signed physician or physician assistant authorization with statement of medical reason is required.

f. 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 ASTM International 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.

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.

i. All items used for sleeping must be used in compliance with manufacturer standards for age and weight of the child.

[ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3556C, IAB 1/3/18, effective 3/1/18]

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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- [Filed ARC 4753C (Notice ARC 4602C, IAB 8/14/19), IAB 11/6/19, effective 12/11/19]
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CHAPTER 153
FUNDING FOR LOCAL SERVICES
[Prior to 7/1/83, see Social Services[770] Ch 131]
[Previously appeared as Ch 131—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
SOCIAL SERVICES BLOCK GRANT

PREAMBLE

This division sets forth the requirements for reporting required for receipt of federal social services block grant (SSBG) funds and service availability and allocation methodology related to those funds.

441—153.1(234) Definitions.

“*Direct services*” means services provided by staff of the department of human services to clients. This includes the administrative support necessary to maintain and oversee services. Direct services are funded with state and federal dollars.

“*State purchase services*” means those services the department purchases in every county statewide. State purchase services are funded with state and federal funds.

441—153.2(234) Development of preexpenditure report.

153.2(1) The department of human services shall develop the social services block grant preexpenditure report on an annual basis. The report shall be developed in accordance with the Code of Federal Regulations, Title 45, Part 96, Subpart G, as amended to July 20, 2000. The report shall describe the services to be funded, in what areas services are available and the amount of funding available. The plan shall also indicate the source of funding.

153.2(2) The department shall issue a proposed preexpenditure report before publication of the final report. The proposed report shall be available for public review and comment:

a. In each local office where a service area manager is based during regular business hours for a two-week period; and

b. On the department’s Internet Web site, www.dhs.iowa.gov.

153.2(3) The time and scope of public review will be announced each year. The announcement will indicate the time the proposed report can be viewed. The department:

a. Shall make this information available on the department’s Internet Web site, www.dhs.iowa.gov, and post signs in each local human services office; and

b. May publish advertisements in each service area listing the time of review.

153.2(4) The department shall accept comments about the preexpenditure report during the specified public review and comment period. Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114. The service area manager may arrange public hearings where testimony will be accepted.

153.2(5) The department shall consider the public comment when developing the final preexpenditure report.

153.2(6) A copy of the final preexpenditure report will be available:

a. In each local office where a service area manager is based; and

b. On the department’s Internet Web site, www.dhs.iowa.gov.

441—153.3(234) Amendment to preexpenditure report.

153.3(1) The preexpenditure report may be amended throughout the year. The department may file an amendment changing the kind, scope or duration of a service. Decisions to change a direct service or state purchase service will be made by the department.

Prior to filing an amendment the department and the county boards of supervisors will evaluate available funds and the effect any change will have on clients.

153.3(2) An amendment in the preexpenditure report will be posted in the local offices affected by the amendment at least 30 days prior to the effective date of the change. However, in the event funding for the service has been exhausted, an amendment shall be posted immediately notifying the public that the service will no longer be available. The service area manager will, whenever possible, give advance notice of a service termination made necessary because funds have been exhausted. When a service is added or extended, an amendment may be posted immediately and a 30-day posting period is not required.

153.3(3) Individuals or groups may submit written comments to the service area manager or to the Division of Fiscal Management, Iowa Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

153.3(4) Nothing in this rule will supersede the requirement for notifying clients of adverse action as provided in 441—130.5(234).

441—153.4(234) Service availability.

153.4(1) A client shall apply for services in the appropriate office of the Iowa department of human services.

a. The department shall determine eligibility according to 441—130.3(234).

b. The department shall develop a case plan to monitor the client's progress toward achieving goals as identified in 441—130.7(234).

153.4(2) An eligible client shall receive a service for which the client is eligible, subject to the provisions of 441—Chapter 130, when the service is listed in the geographic area in which the client resides. The geographic area for direct and state purchase is the state.

153.4(3) To the extent federal law prohibits use of federal funds for provision of social service block grant services to persons the department has defined as eligible, state funds shall be used to pay for these services.

441—153.5(234) Allocation of block grant funds.

153.5(1) The department shall follow a cost allocation plan for determining the appropriate administrative costs to be funded with block grant money.

153.5(2) Funding for services shall be allocated in accordance with the annual budgeting process. The department's annual budget is available for review on the department's Internet Web site at www.dhs.iowa.gov. Costs may be shifted in and between service areas to ensure continued statewide availability of services.

441—153.6(234) Local purchase planning process. Rescinded IAB 7/8/92, effective 7/1/92.

441—153.7(234) Advisory committees. Rescinded IAB 3/6/02, effective 7/1/02.

441—153.8(234) Expenditure of supplemental funds. When supplemental funds are issued through the social services block grant as emergency disaster relief, the department shall administer the funds in compliance with the terms of the federal award rather than the provisions of this division. [ARC 7641B, IAB 3/25/09, effective 3/1/09; ARC 7830B, IAB 6/3/09, effective 7/8/09]

441—153.9 and 153.10 Reserved.

These rules are intended to implement Iowa Code section 234.6.

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

PREAMBLE

Decategorization of child welfare and juvenile justice funding is an initiative intended to establish systems of delivering human services based upon client needs that replace systems based upon a multitude of categorical funding programs and funding sources, each with different service definitions

and eligibility requirements. Decategorization is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

441—153.11(232) Definitions. For the purposes of this division, the following definitions apply:

“*Budget accountability*” means that expenditures for decategorization services from a decategorization project’s funding pool during the state fiscal year do not exceed the total amount of funding available in the funding pool for the state fiscal year.

“*Carryover funding*” means moneys designated for a project’s decategorization services funding pool that remain unencumbered or unobligated at the close of the state fiscal year.

“*Chief juvenile court officer*” mean the judicial department official responsible for managing and supervising juvenile court services operations within one of the eight judicial districts.

“*Decategorization*” means an initiative established pursuant to Iowa Code section 232.188 that is designed to redirect child welfare and juvenile justice funding to services that are more preventive, family-centered, and community-based in order to reduce use of more restrictive approaches.

“*Decategorization agreement*” means the agreement entered into among representatives of the department of human services, juvenile court services, and the county government in one or more counties to implement a decategorization project in accordance with the requirements of Iowa Code Supplement section 232.188 and this division.

“*Decategorization project*” means the county or counties that have entered into a decategorization agreement to implement the decategorization initiative in the county or multicounty area covered by the agreement.

“*Decategorization services funding pool*” or “*funding pool*” means the funding designated for a decategorization project from all sources.

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

“*Governance board*” means a decategorization governance board, which is the group that enters into and implements a decategorization agreement.

“*Service area manager*” means the department official responsible for managing the department’s programs, operations, and child welfare budget within one of the eight department service areas.

“*Unencumbered or unobligated*” means funding within a decategorization services funding pool that is not spent by the project’s governance board for a specific program or purpose by the close of the state fiscal year.

441—153.12(232) Implementation requirements. The decategorization initiative shall be implemented through the creation and operation of decategorization projects. One or more counties may jointly agree to form a decategorization project to implement the initiative. The decategorization initiative shall be implemented in accordance with the following requirements:

153.12(1) *Decategorization agreement.* Representatives from the department, juvenile court services, and county government within the county or counties interested in forming a decategorization project shall develop a written agreement to work together to implement decategorization.

153.12(2) *Department approval.* A decategorization project must request and receive approval from the department director.

153.12(3) *Governance board.* A decategorization project shall be implemented by a decategorization governance board.

a. The department director shall ensure that each decategorization project has an operating governance board that includes:

(1) Representatives designated by administrators of the department and of juvenile court services; and

(2) Officials with the authority to represent county government in the affected county or counties.

b. Decategorization projects may choose to expand their governance boards to include representatives from other entities.

153.12(4) Department information. The service area manager shall provide the governance board with:

a. Information concerning the department service area's funding allocation for department-administered child welfare service programs; and

b. A copy of the service area's child welfare and juvenile justice annual plan.

153.12(5) Juvenile justice information. The chief juvenile court officer shall provide the governance board with information on the judicial district's allocation of funding for juvenile justice service programs.

153.12(6) Support and coordination. The department service area manager and the chief juvenile court officer shall:

a. Work with the governance board throughout each state fiscal year to coordinate planning and to target resources most effectively.

b. Regularly provide the governance board with available data concerning child welfare and juvenile justice needs, service trends and expenditures, child welfare and juvenile justice outcomes, and other relevant issues.

c. Work with the governance board to:

(1) Support board planning and service development; and

(2) Promote effective alignment of available financial resources to enhance preventive, family-centered, and community-based services.

441—153.13(232) Role and responsibilities of decategorization project governance boards. The governance board of a decategorization project shall have the following authority and responsibilities:

153.13(1) Rules of operation. The governance board shall establish and adopt written rules of operation that are available to the public.

153.13(2) Open meetings and records. The governance board shall adhere to statutory requirements for government bodies concerning open meetings and open records procedures as specified in Iowa Code chapters 21 and 22.

153.13(3) Coordination. The governance board shall coordinate project planning, decategorization service decisions, and budget planning activities with the service area manager and the chief juvenile court officer for the county or counties comprising the project.

153.13(4) Right to services. The governance board shall implement the decategorization initiative in a manner that does not limit the legal rights of children and families to receive services.

153.13(5) Community service planning. The governance board shall undertake community planning activities within the county or counties comprising the project. These activities shall be designed to develop services that are more preventive, family-centered, and community-based.

a. As part of decategorization community planning, the governance board shall partner with other community stakeholders to develop service alternatives that provide less restrictive levels of care for children and families within the project area. The governance board shall involve community representatives, including representatives for families and youth and for county organizations, in the development of specific and quantifiable short-term and long-term plans for:

(1) Enhancing preventive, family-centered, and community-based services; and

(2) Reducing reliance on out-of-community care and restrictive interventions.

b. In community planning, the governance board may use information from federal reviews of Iowa's child welfare system and indicators and outcomes from other community planning efforts. The governance board shall coordinate its community planning efforts as much as possible with those of other planning entities in the community, such as but not limited to:

(1) Communities of promise;

(2) Community empowerment;

(3) United Way;

(4) Community partnerships for protecting children;

(5) Comprehensive school improvement planning;

(6) Comprehensive substance abuse agency planning; and

(7) Substance-abuse-free environment (SAFE) program planning.

153.13(6) *Annual service plan.* The governance board shall oversee the development and submission of an annual child welfare and juvenile justice services plan that meets the requirements of rule 441—153.18(232). The governance board shall involve community representatives and county organizations in the development of the plan for the use of the decategorization services funding pool.

153.13(7) *Fiscal management.* The governance board shall manage and have authority over the project's decategorization services funding pool.

a. The governance board shall develop a plan to maintain budget accountability by ensuring during each state fiscal year that there is ongoing accountability for results, fiscal monitoring, and oversight of expenditures from the decategorization services funding pool.

b. Budget planning and decategorization services funding decisions shall be coordinated with the affected service area managers and chief juvenile court officers or their designees throughout each state fiscal year.

c. The governance board shall ensure that expenditures do not exceed the amount of funding available within the funding pool.

d. If necessary, the governance board shall approve actions to reduce expenditures, discontinue programs, or take other action to manage expenditures within the available decategorization services funding pool during each state fiscal year.

153.13(8) *Annual report.* The governance board shall oversee the development and submission of an annual progress report for the decategorization project that meets the requirements of rule 441—153.19(232).

441—153.14(232) *Realignment of decategorization project boundaries.* If a governance board votes to change the composition of counties participating in the project, the governance board shall send a letter to the department director that describes the nature of the proposed project realignment and is signed by each board member who supports the proposed realignment.

153.14(1) If the realignment request involves the move of one or more counties from one decategorization project to another, the governance board of the project receiving the county or counties shall send a letter to the department director expressing support for the realignment.

153.14(2) The department director shall review the request and within 30 days shall provide a written decision to the project governance boards involved.

a. In evaluating the request, the department director shall consider the reasons expressed for the proposed realignment and the community and budgetary impacts of the realignment.

b. The director may consult with governance board representatives and others before making a decision.

441—153.15(232) *Decategorization services funding pool.*

153.15(1) *Creation and composition of pool.* The department shall create the decategorization services funding pool for a project by combining funding resources that may be made available to the project from one or more of the following funding sources:

a. The project's allocation of any funding designated for decategorization in a state appropriation. When the general assembly designates a portion of the department's child welfare appropriation specifically for decategorization services, the designated funds shall be allocated to decategorization project services funding pools. Unless otherwise specified by legislation, the designated funds shall be allocated among decategorization projects based solely on each project's share of the population of children under the age of 18.

b. Child welfare and juvenile justice services funds that are:

(1) Specifically designated and committed in writing to the project by the service area manager; and

(2) Accepted by the project's governance board.

c. Any juvenile justice program funds that are:

(1) Specifically designated and committed in writing to the decategorization project by a chief juvenile court officer; and

(2) Accepted by the project's governance board.

d. Any carryover funds available to the project from funding transfers and from operation of decategorization services during the previous state fiscal year.

e. Funds made available to the project from any other funding source, such as another state agency or a grant awarded to the project. Funds awarded to the project under this provision may be subject to specific conditions, reporting requirements, and expenditure limits specified by the entity that awards funding.

153.15(2) *Use of funding pool.* A governance board shall use the funding pool in accordance with the following requirements:

a. The funding pool shall be used to provide services that meet at least one of the following criteria:

(1) Services are flexible;

(2) Services are individualized;

(3) Services are family-centered;

(4) Services are preventive;

(5) Services are community-based;

(6) Services are comprehensive; or

(7) Services promote coordinated service systems for children and families in order to reduce the use of restrictive approaches that rely on institutional, out-of-home, and out-of-community care.

b. The governance board may use the funding pool for enhancements to the child welfare and juvenile justice service systems within the project.

c. The funding pool shall not be used for any of the following services:

(1) Institutional services;

(2) Out-of-home services; or

(3) Out-of-community services.

d. The funding pool shall be expended in accordance with statutes and rules regarding vendor solicitation and service contracting, including Iowa Code chapter 8 and department of administrative services rules at 11—Chapters 106 and 107, Iowa Administrative Code.

153.15(3) *Designation and transfer of department funds.* A service area manager may choose during each state fiscal year to designate and transfer a portion of the service area's child welfare and juvenile justice service allocation to a decategorization project's funding pool. When designating funds, the service area manager and the governance board shall follow these procedures:

a. The service area manager shall provide written notification of any funding designations to the governance boards within the service area by June 1 of the state fiscal year. The service area manager shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of designated funding and provide written notification of acceptance or rejection to the service area manager by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(4) *Designation and transfer of juvenile justice funds.* A chief juvenile court officer may choose to designate and transfer a portion of the judicial district's juvenile justice program funding to a decategorization project's services funding pool. When designating funds, the chief juvenile court officer and the governance board shall follow these procedures:

a. The chief juvenile court officer shall provide written notification of any funding designations to the governance boards within the judicial district by June 1 of the state fiscal year. The chief juvenile

court officer shall specify any special terms and conditions of the funding designation in the written notification to the governance board.

b. The governance board shall consider the offer of funding and shall provide the chief juvenile court officer with written notification of acceptance or rejection of the funding by June 30 of the state fiscal year.

c. If the governance board accepts the designated funding, the funds shall:

(1) Be transferred to the project's decategorization services funding pool; and

(2) Be under the sole management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

d. Any funding from such transfers that remains unencumbered or unobligated at the close of the state fiscal year shall be carryover funding in accordance with subrule 153.15(5).

153.15(5) *Carryover funding.* Funds allocated to a decategorization project from a legislative appropriation for decategorization services and funds designated and transferred to a decategorization project's funding pool that remain unencumbered or unobligated at the close of a state fiscal year are referred to as "carryover funding." The following procedures shall apply to the determination and use of decategorization carryover funding:

a. Upon the close of a state fiscal year, the department shall determine the exact amount of funding that is unencumbered or unobligated in each project's decategorization services funding pool. The department shall collaborate with governance boards to reconcile expenditure records and determine the amount of carryover funding for each decategorization project.

b. Before December 15 of each state fiscal year, the department shall provide each governance board with written notification of the official amount of carryover funding available from the previous state fiscal year.

c. Carryover funding shall not revert to the state general fund but shall remain available to the governance board until the close of the succeeding state fiscal year.

d. Carryover funding shall be under the authority of the project's governance board. These funds shall be available for expenditure for child welfare and juvenile justice systems enhancements and other purposes of the project as determined by the governance board.

e. Any carryover funding not expended by a decategorization project by the close of the succeeding state fiscal year shall revert to the fiscal authority of the department. The department shall return these funds to the state general fund.

441—153.16(232) Relationship of decategorization funding pool to other department child welfare funding. With the exception of any portion of the service area's child welfare allocation that is allocated by law for decategorization services, each service area's child welfare allocation shall be managed under the authority of the respective service area manager as follows:

153.16(1) *Allocation.* Each service area manager receives an allocation from the state appropriation for child welfare and juvenile justice services funding to meet child welfare and juvenile justice needs within all counties comprising the service area. The service area manager is responsible for meeting service needs throughout the service area within that allocation.

153.16(2) *Budgeting.* The service area manager may establish internal child welfare and juvenile justice services budget targets for the counties comprising the service area. Based on budget monitoring and changes in circumstances, the service area manager may revise the child welfare and juvenile justice budget targets within the service area to provide for the safety, permanency, and well-being of children served in the child welfare and juvenile justice systems.

153.16(3) *Transfer to project.* A service area manager may choose to designate and to transfer a portion of the service area's child welfare allocation to the funding pool of a decategorization project. The service area manager may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.16(4) *Communication with the governance board.* The service area manager shall regularly communicate with the governance boards within the service area to provide updated data and other information on child welfare and juvenile justice funding amounts, service expenditures and trends, and other issues in order to assist the governance board in service and budget planning.

441—153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams. Funds allocated by the department among the eight judicial districts for the court-ordered services and graduated sanctions programs shall be managed under the authority of the chief juvenile court officer for each judicial district as follows:

153.17(1) *Allocation.* Each chief juvenile court officer receives an allocation from the state appropriation for the court-ordered services and graduated sanction programs. The chief juvenile court officer is responsible for managing needs for these programs throughout the judicial district within that allocation.

153.17(2) *Budgeting.* The chief juvenile court officer may establish internal budget targets for expenditures from the court-ordered services and graduated sanction programs for the counties comprising the judicial district. Based on budget monitoring and changes in circumstances, a chief juvenile court officer may revise the budget targets established within the judicial district to provide programs most effectively for children within the district.

153.17(3) *Transfer to project.* A chief juvenile court officer may choose to designate and to transfer a portion of the judicial district's allocation for court-ordered services and graduated sanction programs to the funding pool of a decategorization project. The chief juvenile court officer may ask a governance board to accept specific terms and conditions concerning use of this funding. Once funding is transferred to a governance board, the funding is under the management authority of the governance board, subject to any special terms and conditions agreed to by the governance board.

153.17(4) *Communication with the governance board.* The chief juvenile court officer shall regularly communicate with the governance boards within the judicial district to provide data and other information on juvenile justice program allocation amounts, service expenditures and trends, and other issues that may assist the governance boards in service and budget planning.

441—153.18(232) Requirements for annual services plan. Each decategorization project shall annually develop and submit a child welfare and juvenile justice decategorization services plan.

153.18(1) *Content of plan.* The decategorization services plan shall describe:

a. The project's proposed use of funding from the decategorization services funding pool during the state fiscal year.

b. The community planning and needs assessment process that was used in developing the annual decategorization services plan, including information on:

- (1) The community members and organizations that participated in developing the plan; and
- (2) Efforts to coordinate with other community planning initiatives affecting children and families.

c. The project's specific and quantifiable short-term plans and desired results for the state fiscal year and how these plans align with the project's long-term plans to improve outcomes for vulnerable children and families by enhancing service systems.

d. The methods that the project will use to track results and outcomes during the year.

e. The project's plans for monitoring and maintaining fiscal accountability, which shall include monitoring:

- (1) The performance and results achieved by contractors that receive funding; and
- (2) Expenditures from the decategorization services funding pool throughout the state fiscal year.

f. The project's plans to expend projected carryover funds by the conclusion of the state fiscal year.

153.18(2) *Submission of plan.* The decategorization services plan shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by October 1 of each state fiscal year.

441—153.19(232) Requirements for annual progress report. Each decategorization project shall develop and submit an annual progress report.

153.19(1) Content of report. At a minimum, the progress report shall:

- a. Summarize the project's key activities and the progress toward reaching the project's desired outcomes during the previous state fiscal year.
- b. Describe key activities, outcomes, and expenditures for programs and services that received funding from the governance board during the previous state fiscal year.
- c. Describe any lessons learned and planning adjustments made by the governance board during the previous state fiscal year.

153.19(2) Submission of report. The progress report shall be submitted to the department's child welfare administrator and to the Iowa empowerment board by December 1 of each state fiscal year.

These rules are intended to implement Iowa Code Supplement section 232.188.

441—153.20 to 153.30 Reserved.

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES
[Rescinded IAB 3/6/02, effective 5/1/02]

441—153.31 to 153.50 Reserved.

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

PREAMBLE

The state payment program provides 100 percent state funds to pay for local mental health, mental retardation, and developmental disabilities services for eligible adults who have no legal settlement in Iowa. The state payment program is intended to enable all eligible residents to receive services from the county mental health, mental retardation and developmental disabilities services fund through the county central point of coordination, regardless of the resident's legal settlement status.

Three basic principles underlie the state payment program.

First, duration of residency, including legal settlement, is not an eligibility factor for local mental health, mental retardation, and developmental disabilities service programs. The state payment program ensures that each of the local mental health, mental retardation, and developmental disabilities services provided by an Iowa county to residents who have legal settlement is also available to residents of that county who do not have legal settlement.

Second, each state is responsible to provide care and services for its own residents. Iowa provides for residents of Iowa.

Third, one's own family is of primary importance to one's well-being. Thus, the state payment program emphasizes that care and services for a person be provided near the person's own family, unless this is contraindicated or impossible to provide.

441—153.51(331) Definitions.

"Adult" means a person who is 18 years of age or older and is a United States citizen or a qualified alien as defined in 8 U.S.C. §1641.

"Applicant" means a person for whom payment is requested from the state payment program.

"Approved county management plan" means the county plan for mental health, mental retardation, and developmental disabilities services developed pursuant to Iowa Code section 331.439 that has been approved by the department's director.

"Central point of coordination" or *"CPC"* means the administrative entity designated by a county board of supervisors or by the boards of supervisors of a consortium of counties to act as the single entry point to the service system established under an approved county management plan.

“*County of residence*” means the county in Iowa where, at the time an adult applies for or receives services, the adult is living and has established an ongoing presence with the declared, good-faith intention of living permanently or for an indefinite period. The county of residence of an adult who is a homeless person is the county where the adult usually sleeps. “County of residence” does not mean the county where the adult is present for the purpose of:

1. Attending a college or university; or
2. Receiving services in a hospital, a correctional facility, a nursing facility, an intermediate care facility for persons with mental retardation, or a residential care facility.

The county of residence may be transferred using procedures set forth in subrule 153.53(5).

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

“*Division*” means the division of mental health and disability services of the department of human services.

“*Homeless person*” means a person who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is one of the following:

1. A supervised publicly or privately operated shelter designed to provide temporary living accommodations.
2. An institution that provides a temporary residence for persons intended to be institutionalized.
3. A public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

“*Legal representative*” means a person recognized by law as standing in the place or representing the interests of another; for example, a guardian, conservator, custodian, parent of a minor, or the executor, administrator or next of kin of a deceased person.

“*Legal settlement*” is a legal status as defined in Iowa Code sections 252.16 and 252.17.

“*Member*” means a person authorized by the division to receive benefits from the state payment program.

“*Provider*” means a provider of mental health, mental retardation, or developmental disabilities services that has a valid contract for the service with a county to provide services under a county management plan.

“*Resident,*” for purposes of division IV of this chapter, means a person who is present in the state and who has established an ongoing presence with the declared, good-faith intention of living in Iowa permanently or for an indefinite period.

441—153.52(331) Eligibility requirements. To be eligible for the state payment program, an applicant must meet all of the following conditions.

153.52(1) *Adult status.* The applicant shall be an adult as defined in 441—153.51(331).

153.52(2) *Residency.* The applicant shall be a resident of Iowa, present in the state and without legal settlement in an Iowa county. The applicant shall not be in Iowa for purposes of a visit or vacation nor be traveling through the state to another destination at the time of application for services.

153.52(3) *Eligibility under county management plan.* The applicant shall meet the eligibility criteria established in the approved county management plan for the applicant’s county of residence.

153.52(4) *Payment source.* The applicant shall have no other political entity, organization, or other source responsible for provision of or payment for the needed services nor be eligible to have the service funded or provided at no additional cost to the state by another state-funded or federally funded facility or program. The department may, on a case-by-case basis, attempt collection from a legally responsible entity.

441—153.53(331) Application procedure.

153.53(1) *Initiation of application.* The county CPC or the CPC’s designee shall be responsible for applying for state payment program funding for any person who may be eligible and whose county of residence is that county.

a. When an applicant is awaiting discharge from a state mental health institute or state resource center, the facility’s social worker shall initiate the application and forward it to the CPC of the applicant’s

county of residence for completion. If the applicant has no clear county of residence, the application shall be forwarded to the county where the applicant intends to establish residency upon discharge. This county may be designated by the applicant's declaration.

b. Applications shall be made only with the knowledge and consent of the applicant or the applicant's legal representative.

153.53(2) Application requirements. The CPC or the CPC's designee shall complete the application, preferably in electronic format. A complete application shall include:

a. A funding request for the applicant showing:

- (1) The services being requested,
- (2) The total monthly dollar amount needed for the services requested, and
- (3) The chart of accounts codes from the county billing system for the requested services.

b. A copy of a legal settlement worksheet that is completed in accordance with provisions of Iowa Code chapter 252 and other applicable laws and rulings of courts; and

c. The client profile report (or equivalent) from a CPC application that contains information necessary for the division to enter the member into the data system used for payment processing.

153.53(3) Application submission. The CPC or the CPC's designee shall:

a. Submit the complete application as defined in subrule 153.53(2) to the division within 15 business days of the date the CPC or designee receives a completed and signed CPC application form containing a properly completed legal settlement worksheet.

b. Generate a delivery receipt for the application, whether sent to the division by E-mail, fax, or certified mail. The division may require the delivery receipt when it is alleged that an application was sent but the division has no record of receiving the application.

153.53(4) Application date.

a. Waiting list not in effect. When a waiting list is not in effect, the application date shall be the latest of the following dates:

- (1) The date on court commitment documents,
- (2) The date on the CPC application form, or
- (3) 60 days before the division receives the complete application, if the complete application is received more than 60 days after the date on the CPC application form.

b. Waiting list in effect. When a waiting list is in effect pursuant to subrule 153.54(5), the date of application shall be:

- (1) The date on court commitment documents, or
- (2) The date the application is moved off the waiting list.

153.53(5) Transfer of county of residence. The designated county of residence for an adult may be transferred when it seems more reasonable for the county in which the person is receiving services to assume management of the services.

a. Examples of situations where transfer may be reasonable include, but are not limited to:

(1) The person receiving services has been in a facility for more than a year; and the person no longer has any connection to the county of residence, such as relatives who live there, and, so far as anyone can tell, has no desire to return to the county of residence.

(2) The person receiving services was in the state and county of residence for such a short time before needing services that no real attachment was established in the county of residence.

(3) The person is a student attending a college or university but lives and works in the community 12 months per year.

b. If the county of residence desires a transfer and the county in which the person is receiving services agrees, the county accepting the transfer shall notify the department's state payment program manager. The new county of residence shall complete the application procedures, if necessary, and maintain responsibility for the person's case.

c. If the county of residence desires a transfer and the county in which the services are being received does not agree, the county of residence may appeal for resolution to the residency team established by the mental health, mental retardation, developmental disabilities, and brain injury

commission. Either county may appeal the decision of the residency team using the procedures in 441—Chapter 7.

[ARC 8319B, IAB 12/2/09, effective 11/1/09; ARC 8486B, IAB 1/13/10, effective 1/1/10; ARC 8611B, IAB 3/10/10, effective 4/14/10; ARC 8612B, IAB 3/10/10, effective 4/14/10]

441—153.54(331) Eligibility determination.

153.54(1) Approval by county.

a. The CPC or the CPC's designee shall determine whether an applicant is eligible for services based on the eligibility guidelines contained in the approved county management plan for the applicant's county of residence.

b. The county shall apply any policies and procedures regarding waiting lists to state payment program applicants in the same manner as it applies them to persons who have legal settlement in that county.

153.54(2) Certification by the department. Within 15 business days after receipt of a complete application as specified in subrule 153.53(2), division staff shall certify the applicant's eligibility for the state payment program to the central point of coordination.

a. The applicant's legal settlement status shall be ascertained in accordance with Iowa Code sections 252.16 and 252.17 and with other applicable laws, rulings of courts and opinions of the Iowa attorney general.

b. An application shall be approved only when funds are available. When funds are insufficient, the application shall be placed on a statewide waiting list pursuant to subrule 153.54(5).

153.54(3) Effective date of eligibility.

a. An applicant's eligibility for state payment program funding shall be effective from the application date as defined in subrule 153.53(4).

b. Each member shall be assigned a payment slot number based on the member's application date and commitment status.

(1) Members under a court-ordered involuntary commitment shall be considered the first priority for payment slot number assignment, in order of oldest commitment date first. The CPC shall notify the department within seven days of the date when the commitment order is released. When the commitment order is released, the member shall be reassigned a payment slot according to subparagraph 153.54(5) "b"(2).

(2) Slot number assignment for members who are not under an involuntary commitment order shall be based on the application date. For a member who was on a commitment order which has been released, the application date is the date of the member's first commitment order or the member's original application date, whichever is earliest. If there are multiple members with the same application date, the members will be prioritized by the birth month and day (earliest birth date first). If there are multiple members with the same birth month and day, the last four digits of the members' social security numbers will be used, with the lowest number being considered first.

153.54(4) Notification of eligibility decisions. The CPC or the CPC's designee shall notify the applicant or member of the following decisions in accordance with CPC requirements and procedures:

a. Certification of the applicant's eligibility.

b. A change in a member's services, including termination of service.

153.54(5) Waiting list. The department shall start a waiting list when analysis of submitted expenditure reports indicates that the amount of funds needed to pay for the currently assigned payment slots exceeds the state payment program appropriation.

a. *Notice of waiting list.* The department shall notify county CPCs:

(1) Before implementing a waiting list, and

(2) Promptly when the department determines a waiting list is no longer required.

b. *Placement on the waiting list.* When a waiting list is in effect, all new applications shall be placed on the waiting list with the exception of applicants who are subject to an involuntary commitment. Applicants who are subject to an involuntary commitment are exempted from waiting list placement for the services listed on the court order when the CPC includes a copy of relevant court orders directing

services under Iowa Code chapter 229 for which payment is sought. If this documentation is not included, the application will be placed on the waiting list.

c. Movement off the waiting list. The department shall review the waiting list every 30 days. As funds are determined available, applications shall be moved off of the statewide waiting list. Applicants shall be served on a first-come, first-served basis, as determined by the date and time the complete application is received in the division office.

(1) In cases where applications are received simultaneously, the applicants will be prioritized by the birth month and day (earliest birth date first).

(2) If there are multiple applicants with the same birth month and day, the last four digits of the applicants' social security numbers will be used, with the lowest number being considered first.

d. Notification of applicant status. The department shall notify the CPC of each applicant's status quarterly, unless an application can be removed from the waiting list sooner. When the department notifies the CPC that an application can be removed from the waiting list, the CPC shall:

(1) Verify with the applicant that the services are still needed, and

(2) Notify the applicant that service funding is available for services identified.

[ARC 8319B, IAB 12/2/09, effective 11/1/09; ARC 8486B, IAB 1/13/10, effective 1/1/10; ARC 8611B, IAB 3/10/10, effective 4/14/10; ARC 8612B, IAB 3/10/10, effective 4/14/10]

441—153.55(331) Eligible services. Services eligible for reimbursement under the state payment program are the services defined in the approved county management plan of the applicant's county of residence.

153.55(1) Purchased services.

a. Service management may be provided through a county CPC process during the period for which services are paid.

b. The county may pay for services as long as the member is eligible and the following criteria are met:

(1) The member is receiving a service that requires funding from the state payment program.

(2) The service is provided under the approved county management plan of the member's county of residence.

(3) The member's county of residence provides or pays for the service from the county mental health, mental retardation, and developmental disabilities services fund for persons who have legal settlement in the county.

(4) Service providers bill the other payment systems for which the member is eligible before billing the county of residence.

153.55(2) Excluded costs. The following costs are excluded from payment by the state payment program:

a. Services received before the effective date of eligibility.

b. The cost of local services that the member is eligible to have funded by private sources or by other state or federal programs or funds, such as medical assistance program services or services provided in a state institution.

c. Scheduled appointments or consultations for which the member did not appear.

d. Service management (county chart of accounts numbers beginning with 22-000) for members eligible for Medicaid targeted case management, unless the Iowa plan contractor decertifies the member for case management services.

e. Services described by the following county chart of accounts codes:

(1) 4x03, information and referral.

(2) 4x04, consultation.

(3) 4x11, direct administrative.

(4) 4x12, purchased administrative.

(5) 4x21-374, case management Medicaid match.

(6) 4x32-328, home/vehicle modification.

[ARC 8486B, IAB 1/13/10, effective 1/1/10; ARC 8612B, IAB 3/10/10, effective 4/14/10]

441—153.56(331) Program administration.**153.56(1) CPC responsibilities.**

a. Financial participation on the part of the member shall be governed by the financial participation provisions of the approved county management plan of the member's county of residence.

b. The CPC or the CPC's designee shall submit to the division's state payment program manager by the fifth business day of each month a report on the eligible services paid for during the previous month. The report shall be submitted electronically and shall include the following data in each record:

- (1) The calendar month and year in which the county made the payment.
- (2) The name of the county submitting the information.
- (3) The member's name.
- (4) The member's state identification number.
- (5) The member's identification number as assigned under subparagraph 153.56(2) "a"(2).
- (6) The member's diagnostic group code.
- (7) The provider's name.
- (8) The chart of accounts code for each service paid.
- (9) The number of units paid (if applicable).
- (10) The beginning date of each service for which the county paid.
- (11) The ending date of each service for which the county paid.
- (12) The dollar amount paid.

c. The CPC or the CPC's designee shall include payments made on behalf of members in the data warehouse annual reports required by 441—Chapter 25, Division IV.

153.56(2) Department responsibilities. As the sponsoring agency, the department shall be responsible for:

a. Enrolling members as necessary to produce payment to the counties, including:

- (1) Maintaining member information in the data system for payment;
- (2) Notifying counties of the member identification number required for billing; and
- (3) Closing data system files on members as directed by the counties, or when the member has not had any payments processed for a six-month period.

b. Verifying receipt of monthly payment report files. Within 15 business days of receipt of each county's monthly payment report file, the department shall:

- (1) Identify the county's payment amount for that month and the number of clients included in the payment; and
- (2) Notify the county of any clients whose costs were denied and the reason for the denial.

c. Generating and reconciling payments to the counties.

d. Receiving and auditing reports of member activity and expenditures from the counties.

153.56(3) Payment to counties. The following policies shall govern payment to counties for services furnished to members:

a. Monthly payment. Beginning in May 2007, the department shall make a monthly payment to each county based on the expense report for the previous month that was submitted by the county pursuant to paragraph 153.56(1) "b." The department shall process monthly payments by the twentieth day of each month.

b. Prospective payment. The department may make a prospective payment to the county for cash flow purposes by July 10 of each year.

(1) The prospective payment shall be based on the sum of the expense reports that the department received from the county in April, May, and June of that year.

(2) For the state fiscal year ending June 30, 2007, the payments made to the county on or before April 1, 2007, shall be considered the prospective payment.

c. Payment reconciliation. The department and counties shall reconcile the total of the prospective payment and monthly payments made to a county with the total actual expenses paid by the county for that same period.

d. Payment adjustment. Beginning in April of each year, the department may adjust the monthly payment to the county to:

- (1) Spend down the balance of the prospective payments previously made; or
 - (2) Make additional payment to ensure that the county has sufficient moneys for cash flow purposes.
- e. Deductions.* For the state fiscal year ending June 30, 2007, moneys that the county received but did not expend, according to the report required by paragraph 153.56(1)“b,” shall be deducted from the county’s subsequent payment.

[ARC 8486B, IAB 1/13/10, effective 1/1/10; ARC 8612B, IAB 3/10/10, effective 4/14/10]

441—153.57(331) Reduction, denial, or termination of benefits. The member’s state payment program benefits may be denied, terminated, or reduced according to the provisions of the approved county management plan of the member’s county of residence.

153.57(1) Termination of eligibility. A member shall remain eligible until:

- a.* Reimbursement for episodic commitment costs has been made to the county if the member was enrolled for commitment costs only;
- b.* The CPC in the county of residence notifies the state payment program manager that the member is no longer eligible;
- c.* No services have been reported for the member for six months; or
- d.* The member is disenrolled pursuant to subrule 153.57(2).

153.57(2) Disenrollment. If instituting a waiting list does not adequately address the funding shortfall, the department shall begin disenrollment of members.

a. Members who are enrolled and receiving services being reimbursed by the state and who are not under court-ordered involuntary commitment shall be disenrolled beginning with the highest payment slot number first.

b. The department shall notify the member and the CPC when a member is to be disenrolled. The department shall give the member at least ten days’ notice of disenrollment pursuant to 441—subrule 16.3(1). The department shall give a member receiving any residential service 30 days’ notice of disenrollment from the program consistent with department of inspections and appeals’ rule 481—57.14(135C).

c. Any member who is disenrolled shall be placed on the waiting list as provided in subrule 153.54(5).

[ARC 8486B, IAB 1/13/10, effective 1/1/10; ARC 8612B, IAB 3/10/10, effective 4/14/10; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—153.58(331) Appeals.

153.58(1) Decisions regarding denial or termination of state payment program eligibility, including disenrollment, may be appealed to the department pursuant to 441—Chapter 7. Continuation of assistance will be granted pursuant to rule 441—7.17(17A).

153.58(2) Decisions (other than eligibility) adversely affecting applicants or members shall be appealed pursuant to the county CPC’s appeal provisions.

[ARC 8319B, IAB 12/2/09, effective 11/1/09; ARC 8486B, IAB 1/13/10, effective 1/1/10; ARC 8611B, IAB 3/10/10, effective 4/14/10; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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TITLE XV
INDIVIDUAL AND FAMILY SUPPORT
AND PROTECTIVE SERVICES
CHAPTER 170
CHILD CARE SERVICES
[Prior to 7/1/83, Social Services[770] Ch 132]
[Previously appeared as Ch 132—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, or a nonregistered family child care home.

[ARC 2169C, IAB 9/30/15, effective 1/1/16]

441—170.1(237A) Definitions.

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

1. Loss or misfiling 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 department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

“Child care” means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

“Child with protective needs” means a child who is not in foster care and has a case file that identifies child care as a safety or well-being need to prevent or alleviate the effects of child abuse or neglect. Child care is provided as part of a safety plan during a child abuse or child in need of assistance assessment or as part of the service plan established in the family's case plan. The child must have:

1. An open child abuse assessment;
2. An open child in need of assistance assessment;
3. An open child welfare case as a result of a child abuse assessment;
4. A petition on file for a child in need of assistance adjudication; or
5. Adjudication as a child in need of assistance.

“Child with special needs” means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified intellectual disability professional to have a condition which impairs the child's intellectual and social functioning.

3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

"Client" means a current or former recipient of the child care assistance program.

"Client error" means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;
4. Failure to comply with the need for service requirements.

"Department" means the Iowa department of human services.

"Food services" means the preparation and serving of nutritionally balanced meals and snacks.

"Fraudulent means" means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

"In-home" means care which is provided within the child's own home.

"Migrant seasonal farm worker" means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.
2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.
3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

"On-line or distance learning" means training such as, but not limited to, training conducted over the Iowa communications network, on-line courses, or web conferencing. The training includes:

1. Interaction between the instructor and the student, such as required chats or message boards;
2. Mechanisms for evaluation and measurement of student achievement.

"Overpayment" means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

"Parent" means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

"Program and activities" means the daily schedule of experiences in a child care setting.

"PROMISE JOBS" means the department's training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93.

"Provider" means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, or a nonregistered child care home.

"Provider error" means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;
2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;
4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;
5. Failure to maintain a copy of Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, signed by the parent and the provider.

“*Recoupment*” means the repayment of an overpayment by a payment from the client or provider or both.

“*Relative*” means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

“*Supervision*” means the care, protection, and guidance of a child.

“*Transportation*” means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

“*Unit of service*” means a half day which shall be up to 5 hours of service per 24-hour period.

“*Vocational training or education*” means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

Training may be approved for high school completion activities, high school equivalency, adult basic education, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1525C, IAB 7/9/14, effective 7/1/14; ARC 1606C, IAB 9/3/14, effective 10/8/14; ARC 2169C, IAB 9/30/15, effective 1/1/16; ARC 2555C, IAB 6/8/16, effective 7/1/16]

441—170.2(237A,239B) Eligibility requirements. A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

170.2(1) Financial eligibility. Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa’s median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

a. Income limits. For initial and ongoing eligibility, an applicant family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” cannot exceed the amounts in subparagraphs 170.2(1)“a”(1) to (3). If, at the time of eligibility redetermination as described in subrule 170.3(5), a family’s nonexempt gross monthly income exceeds the limits established in 170.2(1)“a”(1) or (2) but not (3), the family shall remain eligible for an additional 12-month period or until their income exceeds that stated in (3), whichever comes first.

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa’s median family income, if that figure is lower than the standard in subparagraph (1) or (2).

b. Exceptions to income limits.

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

c. Determining gross income. Eligibility shall be determined using a projection of income based on the best estimate of future income. In determining a family’s gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)“d.”

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation,

workers' compensation, alimony, child support, veterans pensions, cash payments, casino profits, railroad retirement, permanent disability insurance, strike pay and living allowance payments made to participants of the AmeriCorps program. "Net profit from self-employment" means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

(3) When income received weekly or once every two weeks is projected for future months, income shall be projected by adding all income received in the period being used for the projection and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

d. Income exclusions. The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food and Nutrition Act of 2008.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under the Workforce Investment Act (WIA).

(18) Stipends received for participating in the foster grandparent program.

(19) The first \$65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

- (27) Any adoption subsidy payments received from the department.
- (28) Federal or state earned income tax credit.
- (29) Payments from the Iowa individual assistance grant program (IIAGP).
- (30) Payments from the transition to independence program (TIP).
- (31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

- (32) Reimbursement from the employer for job-related expenses.
- (33) Stipends from the preparation for adult living (PAL) program.
- (34) Payments from the subsidized guardianship waiver program.
- (35) The earnings of a child aged 18 or under who is a full-time student.
- (36) Census earnings received by temporary workers from the Bureau of the Census.
- (37) Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

e. Family size. The following people shall be included in the family size for the determination of eligibility:

- (1) Legal spouses (including common law) who reside in the same household.
- (2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.
- (3) A child or children who live with a person or persons not legally responsible for the child's support.

f. Effect of temporary absence. The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

- (1) An absence for the purpose of education or employment.
- (2) An absence due to medical reasons that is anticipated to last less than three months.
- (3) Any absence when the person intends to return home within three months.

g. Resource limits. For initial and ongoing eligibility, family resources may not exceed \$1 million.

170.2(2) General eligibility requirements. In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

a. Age. Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19. When a child reaches the age of 13, or, as applicable, the age of 19, during the certification period, eligibility shall continue until the end of the approved certification period.

b. Need for service. Except for assistance provided under subparagraph 170.2(2)"b"(3), assistance shall be provided to a two-parent family only during the parents' coinciding hours of participation in training, employment, or job search. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time training may be approved only if the number of credit hours to complete training is less than that required for full-time status, the required prerequisite credits or remedial course work is less than that required for full-time status, or training is not offered on a full-time basis. Child care services may be provided for the parent's hours of participation in the academic or vocational training and for actual travel time between the child care location and the training facility.

1. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending

dates that fall within two adjacent calendar months but shall only count as one month. Time spent in high school completion, adult basic education, high school equivalency, or English as a second language does not count toward the 24-month limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

2. Payment shall not be approved for child-care during training in the following circumstances:

- Labor market statistics for a local area indicate low employment potential for workers with that training. Exceptions may be made when the parent has a job offer before entering the training or if a parent is willing to relocate after training to an area where there is employment potential. Parents willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the parent.

- The training is for jobs paying less than minimum wage.

- A parent who possesses a baccalaureate degree wants to take additional college coursework unless the coursework is to obtain a teaching certificate or complete continuing education units.

- The course or training is one that the parent has previously completed.

- The parent was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.

- The education is in a field in which the parent will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.

- The parent wants to participate in on-line or distance learning from the parent's own home, and the training facility does not require specified hours of attendance.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment and for actual travel time between the child care location and the place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent has a child with protective needs for child care.

(4) The parent is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but due to medical incapacity is unable to care for the child or participate in work or training, as verified by a physician.

1. Eligibility under this paragraph is limited to parents who become medically incapacitated while eligible for child care assistance based on the need criteria in subparagraph 170.2(2) "b"(1) or 170.2(2) "b"(2).

2. Child care assistance shall continue to be available for up to 90 consecutive days after the parent becomes medically incapacitated. Assistance beyond 90 days may be approved by the service area manager or designee if extenuating circumstances are verified by a physician.

3. The number of units of service authorized shall be determined as follows:

- For a single-parent family or for a two-parent family where both parents are incapacitated, the number of units authorized for the period of incapacity shall not exceed the number of units authorized for the family before the onset of incapacity.

- For a two-parent family where only one parent is incapacitated, the units of service authorized shall be based on the need of the parent who is not incapacitated.

(5) The parent is looking for employment. Child care for job search hours shall be limited to only those hours the parent is actually looking for employment, including travel time. Job search shall be limited to a maximum of 90 consecutive calendar days.

1. For applicants, job search shall be approved for a maximum of 90 consecutive calendar days. If the parent has not started employment within 90 days, assistance shall be canceled.

2. For ongoing participants, job search shall be limited to a maximum of 90 consecutive calendar days and will be treated the same as a temporary lapse in need as described at 170.2(2) "b"(9) and (10).

(6) The parent needs child care services due to participation in activities approved under the PROMISE JOBS program.

(7) The family is part of the family investment program and there is a need for child care services due to employment or participation in vocational training or education. A family who meets this requirement due to employment is not required to work a minimum number of hours. If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

(8) The parent is employed and participating in academic or vocational training for 28 or more hours per week or an average of 28 or more hours per week in the aggregate, during the month. Child care services may be provided for the hours of employment, the hours of participation in academic or vocational training and for actual travel time between the child care location and the place of employment or training. All of the requirements relating to academic or vocational training found at subparagraph 170.2(2)“b”(1), except for the requirement to be enrolled full-time, apply to the part-time training in this subparagraph.

(9) Family eligibility shall continue during an approved certification period when a temporary lapse in need for service for a parent established under this subparagraph occurs. A temporary lapse is defined as:

1. Any time-limited absence from work or a training or education program for a parent due to:
 - Need to care for a family member.
 - An illness.
 - Maternity leave.
 - Family Medical Leave Act (FMLA) situations for household members.
 - Participation in a treatment/rehabilitation program.
2. Any reduction in employment or education/training hours that fall below the minimum number required at 170.2(2)“b”(1), (2) or (8) as long as the parent continues to work or attend training or education.
3. Any student holiday or break for a parent participating in training or education.
4. Any interruption in work for a seasonal worker who is not working between regular industry work seasons.
5. Any other cessation of work or attendance at a training or education program that does not exceed three months.

(10) Family eligibility shall be canceled if the lapse in need is not temporary because the lapse will continue for more than 3 consecutive months.

c. Residency. To be eligible for child care services, the person must be living in the state of Iowa. “Living in the state” shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

d. Citizenship. As a condition of eligibility, the applicant shall attest to the child’s citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0462(S), Health and Financial Support Application. Child care assistance payments may be made only for a child who:

- (1) Is a citizen or national of the United States; or
- (2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child’s entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or
2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

e. Cooperation. Parents shall cooperate with the department when the department selects the family’s case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information

supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family's child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

170.2(3) Priority for assistance. Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

a. Priority groups. As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members, for at least 28 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members, for at least 28 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

b. Exceptions to priority groups. The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

(4) Families that are experiencing homelessness.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2) "b" except at review or redetermination.

170.2(4) Reporting changes. The parent may report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported within ten calendar days, the effective date of the change shall be the date when the change is reported to the department office or the PROMISE JOBS office.

c. Exceptions. The following changes must be reported:

(1) Changes in income when the family's gross monthly income exceeds 85 percent of Iowa's median family income.

(2) A lapse in a parent's need for service found in paragraph 170.2(2) "b" that is not temporary.

(3) A change in residency outside of the state of Iowa.

(4) No eligible child remains in the home.

d. The department worker shall disregard any reported changes that are not required to be reported unless the change would cause the authorized units to be increased or the family copay amount to be decreased.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1525C, IAB 7/9/14, effective 7/1/14; ARC 1606C, IAB 9/3/14, effective 10/8/14; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17; ARC 3791C, IAB 5/9/18, effective 7/1/18; ARC 4470C, IAB 6/5/19, effective 7/1/19]

441—170.3(237A,239B) Application and determination of eligibility.

170.3(1) Application process.

a. Application for child care assistance may be made at any local office of the department on:

- (1) Form 470-3624 or 470-3624(S), Child Care Assistance Application,
- (2) Form 470-0462 or 470-0462(S), Health and Financial Support Application, or
- (3) Form 470-4377 or 470-4377(S), Child Care Assistance Review, when returned after the end of the certification period.

b. The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

c. The date of application is the date a signed application form containing a legible name and address is received in the department office. An electronic or paper application delivered to a closed office is considered to be received on the first day following the day the office was last open that is not a weekend or state holiday.

d. Families who are determined eligible for child care assistance shall be approved for a certification period of at least 12 months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

170.3(2) Exceptions to application requirement. An application is not required for:

- a. A person who is participating in activities approved under the PROMISE JOBS program.
- b. Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients. The date of application is the date the family requests child care assistance from the department.
- c. Children with protective needs.
- d. Child care services provided under a court order.
- e. Families whose application has been denied for failure to provide requested information who have provided all necessary information to determine eligibility within 14 days of the denial of the application, or by the next working day if the fourteenth day falls on a weekend or state holiday.

170.3(3) Application processing. The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received. This time limit shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expires, or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

a. The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and shall:

- (1) Inform the family through the notice of decision; and
- (2) Inform the family's provider through the notice of decision or through Form 470-4444, Certificate of Enrollment.

b. The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility.

c. The effective date of assistance shall be the date of application or the date the need for service began, whichever is later. When an application is not required as described under subrule 170.3(2), the effective date shall be as follows:

- (1) For a person participating in activities under the PROMISE JOBS program, the effective date of child care assistance shall be the date the person becomes a PROMISE JOBS participant as defined

in rule 441—93.1(239B) or the date the person has a need for child care assistance to participate in an approved PROMISE JOBS activity as described in 441—Chapter 93, whichever is later.

(2) For a family receiving family investment program benefits, the effective date of child care assistance shall be no earlier than the effective date of family investment program benefits, or 30 days before the date of application for child care assistance, or the date the need for service began, whichever is the latest.

(3) For a family with protective service needs, the effective date of assistance shall be the date the family signs Form 470-0615 or 470-0615(S), Application for All Social Services.

(4) When child care services are provided under a court order, the effective date of assistance shall be the date specified in the court order or the date of the court order if no date is specified.

(5) For a family whose application was denied for failure to provide requested information but who provides all information necessary to determine eligibility, including verification of all changes in circumstances, within 14 days of the denial, the effective date of assistance shall be the date that all information required to establish eligibility is provided. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information.

170.3(4) *Waiting lists for child care services.* When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

a. The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

b. When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

170.3(5) *Review and redetermination.* The department shall redetermine a family's financial and general eligibility for child care assistance at least every 12 months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP), persons whose earned income was taken into account in determining the needs of FIP recipients, and parents who have children with protective needs, because these families are deemed financially eligible so long as the FIP eligibility or need for protective services continues.

a. If FIP or protective services eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

b. The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility, except when the family is not required to complete a review form as provided in paragraph 170.3(5)“c.”

(1) The department shall issue a notice of expiration for the child care assistance certification period on Form 470-4377 or 470-4377(S).

(2) If the family does not return a complete review form to the department by the end of the certification period, the family must reapply for benefits, except as provided in paragraph 170.3(6)“b.” A complete review form is Form 470-4377 or 470-4377(S) with all items answered that is signed and dated by the applicant and is accompanied by all verification needed to determine continued eligibility.

c. Families who have children with protective needs and families who are receiving child care assistance because the parent is participating in activities under the PROMISE JOBS program are not required to complete Form 470-4377 or 470-4377(S).

(1) The department shall issue a notice of expiration for the child care assistance certification period on the notice of decision when the department approves the family's certification period.

(2) The department shall gather information needed to redetermine general eligibility. If the department needs information from the family, the department will send a written request to the family. If the family does not return the requested information by the due date, the family must reapply for child care assistance, except as provided in paragraph 170.3(6) "b."

d. Families who apply for child care assistance because the parent is seeking employment are not subject to review requirements because eligibility is limited to 90 consecutive calendar days. This waiver of the review requirement applies only when the parent who is seeking employment does not have another need for service.

170.3(6) Reinstatement.

a. Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished. If there is a change in circumstances, the change must be verified before the case will be reinstated.

b. Assistance shall be reinstated without a new application when the case was canceled for failure to provide requested information but all information necessary to determine eligibility, including verification of all changes in circumstances, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information. The effective date of child care assistance shall be the date that all information required to establish eligibility is provided.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17]

441—170.4(237A) Elements of service provision.

170.4(1) Case file. The child welfare case file shall document the eligibility for service under 170.2(2) "b"(3).

170.4(2) Fees. Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

a. Sliding fee schedule.

(1) The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2019:

Level	Monthly Income According to Family Size													Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	11	12	13+	1	2	3 or more
A	\$989	\$1,340	\$1,689	\$2,039	\$2,389	\$2,739	\$3,088	\$3,439	\$3,789	\$4,138	\$4,489	\$4,838	\$5,188	\$0.00	\$0.00	\$0.00
B	\$1,041	\$1,410	\$1,778	\$2,146	\$2,515	\$2,883	\$3,251	\$3,620	\$3,988	\$4,356	\$4,725	\$5,093	\$5,461	\$0.20	\$0.45	\$0.70
C	\$1,070	\$1,449	\$1,828	\$2,206	\$2,585	\$2,964	\$3,342	\$3,721	\$4,100	\$4,478	\$4,857	\$5,236	\$5,614	\$0.45	\$0.70	\$0.95
D	\$1,099	\$1,489	\$1,878	\$2,266	\$2,656	\$3,044	\$3,433	\$3,823	\$4,211	\$4,600	\$4,990	\$5,378	\$5,767	\$0.70	\$0.95	\$1.20
E	\$1,130	\$1,531	\$1,930	\$2,330	\$2,730	\$3,130	\$3,529	\$3,930	\$4,329	\$4,729	\$5,129	\$5,529	\$5,928	\$0.95	\$1.20	\$1.45
F	\$1,161	\$1,572	\$1,983	\$2,393	\$2,805	\$3,215	\$3,625	\$4,037	\$4,447	\$4,858	\$5,269	\$5,679	\$6,090	\$1.20	\$1.45	\$1.70
G	\$1,193	\$1,616	\$2,038	\$2,460	\$2,883	\$3,305	\$3,727	\$4,150	\$4,572	\$4,994	\$5,417	\$5,838	\$6,260	\$1.45	\$1.70	\$1.95
H	\$1,226	\$1,660	\$2,094	\$2,527	\$2,962	\$3,395	\$3,828	\$4,263	\$4,696	\$5,130	\$5,564	\$5,997	\$6,431	\$1.70	\$1.95	\$2.20
I	\$1,260	\$1,707	\$2,152	\$2,598	\$3,045	\$3,490	\$3,936	\$4,382	\$4,828	\$5,273	\$5,720	\$6,165	\$6,611	\$1.95	\$2.20	\$2.45
J	\$1,295	\$1,753	\$2,211	\$2,669	\$3,127	\$3,585	\$4,043	\$4,502	\$4,959	\$5,417	\$5,876	\$6,333	\$6,791	\$2.20	\$2.45	\$2.70
K	\$1,331	\$1,802	\$2,273	\$2,743	\$3,215	\$3,685	\$4,156	\$4,628	\$5,098	\$5,568	\$6,040	\$6,511	\$6,981	\$2.45	\$2.70	\$2.95
L	\$1,367	\$1,852	\$2,335	\$2,818	\$3,303	\$3,786	\$4,269	\$4,754	\$5,237	\$5,720	\$6,205	\$6,688	\$7,171	\$2.70	\$2.95	\$3.20
M	\$1,405	\$1,903	\$2,400	\$2,897	\$3,395	\$3,892	\$4,389	\$4,887	\$5,384	\$5,880	\$6,378	\$6,875	\$7,372	\$2.95	\$3.20	\$3.45
N	\$1,444	\$1,955	\$2,466	\$2,976	\$3,488	\$3,998	\$4,508	\$5,020	\$5,530	\$6,040	\$6,552	\$7,062	\$7,573	\$3.20	\$3.45	\$3.70
O	\$1,484	\$2,010	\$2,535	\$3,059	\$3,585	\$4,110	\$4,634	\$5,160	\$5,685	\$6,210	\$6,736	\$7,260	\$7,785	\$3.45	\$3.70	\$3.95
P	\$1,524	\$2,065	\$2,604	\$3,143	\$3,683	\$4,222	\$4,761	\$5,301	\$5,840	\$6,379	\$6,919	\$7,458	\$7,997	\$3.70	\$3.95	\$4.20
Q	\$1,567	\$2,123	\$2,677	\$3,231	\$3,786	\$4,340	\$4,894	\$5,449	\$6,003	\$6,557	\$7,113	\$7,667	\$8,221	\$3.95	\$4.20	\$4.45
R	\$1,610	\$2,180	\$2,749	\$3,318	\$3,889	\$4,458	\$5,027	\$5,598	\$6,167	\$6,736	\$7,307	\$7,876	\$8,445	\$4.20	\$4.45	\$4.70
S	\$1,655	\$2,241	\$2,826	\$3,411	\$3,998	\$4,583	\$5,168	\$5,755	\$6,340	\$6,925	\$7,511	\$8,096	\$8,681	\$4.45	\$4.70	\$4.95
T	\$1,700	\$2,302	\$2,903	\$3,504	\$4,107	\$4,708	\$5,309	\$5,911	\$6,512	\$7,113	\$7,716	\$8,317	\$8,918	\$4.70	\$4.95	\$5.20
U	\$1,748	\$2,367	\$2,985	\$3,602	\$4,222	\$4,840	\$5,457	\$6,077	\$6,695	\$7,312	\$7,932	\$8,550	\$9,167	\$4.95	\$5.20	\$5.45
V	\$1,795	\$2,431	\$3,066	\$3,701	\$4,337	\$4,971	\$5,606	\$6,242	\$6,877	\$7,512	\$8,148	\$8,782	\$9,417	\$5.20	\$5.45	\$5.70

Level	Monthly Income According to Family Size													Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	11	12	13+	1	2	3 or more
W	\$1,845	\$2,499	\$3,152	\$3,804	\$4,458	\$5,111	\$5,763	\$6,417	\$7,069	\$7,722	\$8,376	\$9,028	\$9,681	\$5.45	\$5.70	\$5.95
X	\$1,896	\$2,568	\$3,238	\$3,908	\$4,580	\$5,250	\$5,920	\$6,592	\$7,262	\$7,932	\$8,604	\$9,274	\$9,944	\$5.70	\$5.95	\$6.20
Y	\$1,949	\$2,639	\$3,328	\$4,017	\$4,708	\$5,397	\$6,086	\$6,776	\$7,465	\$8,154	\$8,845	\$9,534	\$10,223	\$5.95	\$6.20	\$6.45
Z	\$2,002	\$2,711	\$3,419	\$4,127	\$4,836	\$5,544	\$6,251	\$6,961	\$7,669	\$8,376	\$9,086	\$9,794	\$10,501	\$6.20	\$6.45	\$6.70
AA	\$2,058	\$2,787	\$3,515	\$4,242	\$4,972	\$5,699	\$6,427	\$7,156	\$7,883	\$8,611	\$9,340	\$10,068	\$10,795	\$6.45	\$6.70	\$6.95
BB	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,500	\$10,000	\$10,500	\$11,500	\$6.70	\$6.95	\$7.20

- (2) To use the chart:
1. Find the family size used in determining income eligibility for service.
 2. Move across the monthly income table to the column headed by that number.
 3. Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.
 4. Choose the fee that corresponds to the number of children in the family who receive child care assistance.

b. Collection. The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

c. Inability of client to pay fees. Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

170.4(3) Method of provision. Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)"b"(3), as long as the conditions in paragraph 170.4(7)"d" are met. When the child meets the need for service under 170.2(2)"b"(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child. The provider must meet one of the applicable requirements set forth below.

a. Licensed child care center. A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

b. Registered child development home. A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

c. Out-of-state provider. A child care provider who is not located in Iowa may be selected by the parent so long as the out-of-state child care provider verifies that the provider meets all of the requirements to be a provider in the state in which the provider operates.

d. Relative care. Rescinded IAB 2/6/02, effective 4/1/02.

e. In-home care. The adult caretaker selected by the parent to provide care in the child's own home shall be sent Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered in-home care providers that include:

(1) Professional development. The provider shall complete:

1. Prior to provider agreement and every five years thereafter, minimum health and safety trainings, approved by the department, in the following content areas:

- Prevention and control of infectious disease, including immunizations.

- Prevention of sudden infant death syndrome and use of safe sleep practices.
- Administration of medication, consistent with standards for parental consent.
- Prevention of and response to emergencies due to food and allergic reactions.
- Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- Prevention of shaken baby syndrome and abusive head trauma.
- Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- Handling and storage of hazardous materials and appropriate disposal of biocontaminants.
- Precautions in transporting children.

Minimum health and safety training may be required prior to the five-year period if content has significant changes which warrant that the training be renewed.

2. Prior to provider agreement, two hours of Iowa's training for mandatory reporting of child abuse.

3. Prior to provider agreement, first-aid and cardiopulmonary resuscitation (CPR) training meeting the following requirements:

- Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.

- First-aid training shall include certification in infant and child first aid.

- The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

- The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

(2) Limits on the number of children for whom care may be provided.

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order.

(4) Conditions that warrant nonpayment.

f. Nonregistered family child care home. A nonregistered child care home shall meet the requirements set forth in 441—Chapter 120.

g. Iowa records checks for in-home care. If a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete and submit the required authorization form(s) to the department. The department shall use the form(s) to conduct Iowa criminal history record and child abuse record checks.

(1) The purpose of these 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 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 in other states.

(3) Records checks shall be repeated every two years and when the department or provider becomes aware of any new transgressions.

h. National criminal history record checks for in-home care. If a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form DCI-45, Waiver Agreement, and Form FD-258, Federal Fingerprint Card.

(1) The provider subject to this check shall submit any other forms required by the department of public safety to authorize the release of records.

(2) The provider subject to this check is responsible for any costs associated with obtaining the fingerprints and for submitting the prints to the department.

(3) Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints.

(4) The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state.

(5) 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 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.

i. Transgressions. If any person subject to the record checks in paragraph 170.4(3)“g” or 170.4(3)“h” has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall follow the process for prohibition or evaluation defined at 441—subrule 120.11(3).

(1) If any person would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant.

(2) A person who continues to provide child care in violation of this rule is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) Components of service program. Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) Levels of service according to age. Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) Provider's individual program plan. Rescinded IAB 2/10/10, effective 3/1/10.

170.4(7) Payment. The department shall make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has a completed Form 470-3871 or 470-3871(S), Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker shall sign this form.

a. Rate of payment. The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)“d,” shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider type and age group as shown in the tables below. To be eligible for the special needs rate, the provider must submit documentation to the child's service worker that the child needing services has been assessed by a qualified professional and meets the definition for “child with special needs,” and a description of the child's special needs, including, but not limited to, adaptive equipment, more careful supervision, or special staff training.

	No QRS		QRS 1 or 2		QRS 3 or 4		QRS 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	\$17.00	\$51.94	\$19.75	\$51.94	\$20.50	\$51.94	\$21.90	\$51.94
Preschool	\$14.75	\$30.43	\$15.50	\$30.43	\$16.40	\$30.43	\$18.69	\$30.43
School Age	\$12.18	\$30.34	\$12.50	\$30.34	\$13.50	\$30.34	\$15.00	\$30.34

Age Group	No QRS		QRS 1 or 2		QRS 3 or 4		QRS 5	
	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	\$12.98	\$19.47	\$13.50	\$20.25	\$13.75	\$20.63	\$14.00	\$21.00
Preschool	\$12.50	\$18.75	\$12.75	\$19.13	\$13.00	\$19.50	\$13.75	\$20.63
School Age	\$10.82	\$16.23	\$11.25	\$16.88	\$12.00	\$18.00	\$12.50	\$18.75

Age Group	No QRS		QRS 1 or 2		QRS 3 or 4		QRS 5	
	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	\$13.00	\$19.50	\$14.00	\$21.00	\$14.50	\$21.75	\$15.00	\$22.50
Preschool	\$12.50	\$18.75	\$13.00	\$19.50	\$13.50	\$20.25	\$15.00	\$22.50
School Age	\$11.25	\$16.88	\$12.00	\$18.00	\$12.50	\$18.75	\$14.00	\$21.00

Age Group	Basic	Special Needs
Infant and Toddler	\$8.19	\$12.29
Preschool	\$7.19	\$10.79
School Age	\$7.36	\$11.04

The following definitions apply in the use of the rate tables:

(1) “Licensed center” shall mean those providers as defined in 170.4(3) “a.” “Child development home A/B” or “child development home C” shall mean those providers as defined in 170.4(3) “b.” “Child care home (not registered)” shall mean those providers as defined in 441—Chapter 120.

(2) Under age group, “infant and toddler” shall mean age two weeks to two years; “preschool” shall mean two years to school age; “school age” shall mean a child in attendance in full-day or half-day classes.

(3) “No QRS” shall mean a provider who is not participating in the quality rating system.

(4) A provider who is rated under the quality rating system shall be paid according to the corresponding QRS payment level in the tables above only during the period the rating is valid as defined in 441—Chapter 118. If the provider’s QRS rating expires, the provider shall be paid according to the “No QRS” payment level.

(5) For a provider rated “QRS 1” through “QRS 4,” if the rating period expires before a new QRS level is approved, the provider will be paid according to the “No QRS” payment level until the new QRS level is approved.

(6) For a provider rated “QRS 5,” if a renewal application is received before the current rating period expires, the provider will continue to be paid according to the “QRS 5” payment level until a decision is made on the provider’s application.

(7) “QRS 1 or 2” shall mean a provider who has achieved a rating of Level 1 or Level 2 under the quality rating system.

(8) “QRS 3 or 4” shall mean a provider who has achieved a rating of Level 3 or Level 4 under the quality rating system.

(9) “QRS 5” shall mean a provider who has achieved a rating of Level 5 under the quality rating system.

b. Payment for days of absence. Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

c. Payment for multiple children in a family. When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

d. Payment for in-home care. Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

e. Limitations on payment. Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

f. Review of the calculation of the rate of payment. Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7) “a” may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director’s designee within 15 calendar days of the decision. The director or director’s designee shall issue the final department decision within 15 calendar days of receipt of the request.

g. Submission of claims. The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay for no more than the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit a claim in one of the following ways:

(1) Using Form 470-4534, Child Care Assistance Billing/Attendance; or

(2) Using an electronic request for payment submitted through the KinderTrack system. Providers using this method shall print Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, to be signed by the provider and the parent. The provider shall keep the signed Form 470-4535 for a period of five years after the billing date.

[ARC 7837B, IAB 6/3/09, effective 7/1/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9490B, IAB 5/4/11, effective 7/1/11; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 0152C, IAB 6/13/12, effective 7/18/12; ARC 0546C, IAB 1/9/13, effective 1/1/13; ARC 0715C, IAB 5/1/13, effective 7/1/13; ARC 0825C, IAB 7/10/13, effective 7/1/13; ARC 0854C, IAB 7/24/13, effective 7/1/13; ARC 1063C, IAB 10/2/13, effective 11/6/13; ARC 1446C, IAB 4/30/14, effective 7/1/14; ARC 1978C, IAB 4/29/15, effective 7/1/15; ARC 2169C, IAB 9/30/15, effective 1/1/16; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 2556C, IAB 6/8/16, effective 7/1/16; ARC 2649C, IAB 8/3/16, effective 10/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17; ARC 3791C, IAB 5/9/18, effective 7/1/18; ARC 4115C, IAB 11/7/18, effective 1/1/19; ARC 4470C, IAB 6/5/19, effective 7/1/19]

441—170.5(237A) Adverse actions.

170.5(1) Provider agreement. The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), if any of the following occur:

a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazard.

b. The provider has submitted claims for payment for which the provider is not entitled.

c. The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.

d. The provider does not meet one of the applicable requirements set forth in subrule 170.4(3).

e. The provider fails to comply with any of the terms and conditions of the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S).

f. The provider submits attendance documentation for payment and the provider knows or should have known that the documentation is false or inaccurate.

g. An overpayment of CCA funds with a balance of \$3,000 or more exists for a provider and that provider fails to enter into a repayment agreement with the department of inspections and appeals (DIA) or does not make payments according to the repayment agreement on file with DIA.

h. The provider is found to have more children in care at one time than allowed for the provider type as found at rule 441—110.6(237A) and 441—subrules 110.13(1), 110.14(1), 110.15(1), 120.6(1) and 170.4(3).

170.5(2) Denial. Child care assistance shall be denied when the department determines that:

a. The client is not in need of service; or

b. The client is not financially eligible; or

c. There is another resource available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or

d. An application is required and the client or representative refuses or fails to sign the application form; or

e. Funding is not available; or

f. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(3) Termination. Child care assistance may be terminated when the department determines that:

a. The client no longer meets the eligibility criteria in subrule 170.2(2); or

b. The client's income exceeds the financial guidelines; or

c. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or

d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or

e. Another resource is available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or

f. Funding is not available; or

g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

170.5(4) Reduction. Authorized units of service may be reduced when the department determines that:

a. Continued provision of service at the current level is not necessary to meet the client's service needs; or

b. Another resource is available to provide the same or similar service free of charge that will meet the client's needs and allow parents to select from the full range of eligible providers; or

c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

170.5(5) Provider agreement sanction. If a Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), is terminated for any of the reasons in subrule 170.5(1), the agreement shall remain terminated for the time periods set forth below:

a. The first time the agreement is terminated, the provider may reapply for another agreement at any time.

b. The second time the agreement is terminated, the provider may not reapply for another agreement for 12 months from the effective date of termination.

c. The third or subsequent time the agreement is terminated, the provider may not reapply for another agreement for 36 months from the effective date of termination.

d. The department shall not act on an application for a child care assistance provider agreement submitted by a provider during the sanction period.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1893C, IAB 3/4/15, effective 7/1/15; ARC 3092C, IAB 6/7/17, effective 7/1/17]

441—170.6(237A) Appeals. Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

441—170.7(237A) Provider fraud.

170.7(1) Fraud. The department shall consider a child care provider to have committed fraud when:

a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000; or

b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000.

170.7(2) Potential sanctions. Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

a. Special review of the provider's claims for child care assistance.

b. Suspension from receipt of child care assistance payment for six months.

c. Ineligibility to receive payment under child care assistance.

170.7(3) Factors considered in determining level of sanction. The department shall evaluate the following factors in determining the sanction to be imposed:

a. *History of prior violations.*

(1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.

(2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

b. *Prior imposition of sanctions.*

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

c. *Seriousness of the violation.*

(1) If the amount fraudulently received is less than \$5,000, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs “a” and “b” is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs “a” and “b” is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

d. Extent of the violation.

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs “a” and “b.”

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs “a” and “b” is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs “a” and “b” is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

170.7(4) Mitigating factors.

a. If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

- (1) Prior provision of provider education.
- (2) Provider willingness to obey program rules.

b. If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph “a” indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

- (1) Suspension from receipt of child care assistance payment for six months; and
- (2) A special review of provider claims.

c. If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph “a” indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

441—170.8(234) Allocation of funds. Rescinded IAB 2/6/02, effective 4/1/02.

441—170.9(237A) Child care assistance overpayments. All child care assistance overpayments shall be subject to recoupment.

170.9(1) Notification and appeals. All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client’s or provider’s request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—paragraph 7.4(3)“i.”

170.9(2) Determination of overpayments. All overpayments due to client, provider, or agency error or due to benefits or payments issued pending an appeal decision shall be recouped. Overpayments shall be computed as if the information had been acted upon timely.

170.9(3) Benefits or payments issued pending appeal decision. Recoupment of overpayments resulting from benefits or payments issued pending a decision on an appeal hearing shall not occur until after a final appeal decision is issued affirming the department.

170.9(4) Failure to cooperate. Failure by the client to cooperate in the investigation of alleged overpayments shall result in ineligibility for the months in question and the overpayment shall be the total amount of assistance received during those months. Failure by the provider to cooperate in the investigation of alleged overpayments shall result in payments being recouped for the months in question.

170.9(5) *Payment agreement.* The client or provider may choose to make a lump-sum payment or make periodic installment payments as agreed to on the notification form issued pursuant to subrule 170.9(6). Failure to negotiate an approved payment agreement may result in further collection action as outlined in 441—Chapter 11.

170.9(6) *Procedures for recoupment.*

a. When the department determines that an overpayment exists, the department shall refer the case to the department of inspections and appeals for investigation, recoupment, or referral for possible prosecution.

b. The department of inspections and appeals shall initiate recoupment by notifying the debtor of the overpayment on Form 470-4530, Notice of Child Care Assistance Overpayment.

c. When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

d. Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

e. Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

f. Recoupment for overpayments caused by both the provider and client shall be collected from both the provider and client equally, 50 percent from the client and 50 percent from the provider.

170.9(7) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than \$35. Recoupment will be waived on nonfraud overpayments of less than \$35 which have been held in suspense for three years.

[ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1893C, IAB 3/4/15, effective 7/1/15; ARC 4973C, IAB 3/11/20, effective 4/15/20]

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CHAPTER 187
AFTERCARE SERVICES PROGRAM

PREAMBLE

These rules define and structure the aftercare services program, which assists youth leaving foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center in their successful transition to adulthood. The aftercare services program, including the preparation for adult living (PAL) program component, helps youth formerly in foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center to continue preparing for the challenges and opportunities presented by adulthood while receiving services and supports. The program offers services and financial benefits to eligible youth up to the age of 23. All services and supports are voluntary.

441—187.1(234) Purpose. The purpose of the aftercare services program is to provide services and supports to youth who are transitioning from foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center to adulthood. The primary goal of the program is for youth to move toward self-sufficiency and to recognize and accept their personal responsibility for the transition from adolescence to adulthood.

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

441—187.2(234) Aftercare services program eligibility requirements. To be eligible for aftercare services, a youth must meet the following requirements:

187.2(1) Residence. The youth must be a resident of Iowa.

187.2(2) Age. The youth must be at least 17 years of age but less than 23 years of age. Program supports and services vary by age.

187.2(3) Out-of-home placement experience.

a. Preservices. The youth must meet eligibility requirements for preservices as described below:

- (1) The youth is at least 17 years of age; and
- (2) The youth was placed in foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center; was adopted after reaching 16 years of age; or entered a subsidized guardianship arrangement after reaching 16 years of age; and
- (3) The youth has access to funding for preservices provided in contract that has not been fully expended for the contract year.

b. Core services. The youth must meet eligibility requirements for core services as described below:

- (1) The youth is 18, 19, or 20 years of age; and
- (2) The youth exited foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center:
 1. On or after the youth's eighteenth birthday; or
 2. Between the ages of 17½ and 18 after having been in any combination of foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center for at least one day in at least 6 of the 12 calendar months prior to the youth leaving placement; or
 - (3) The youth was adopted from foster care on or after the youth's sixteenth birthday; or
 - (4) The youth entered a subsidized guardianship arrangement from foster care on or after the youth's sixteenth birthday.

c. Postservices. The youth must meet eligibility requirements for postservices as described below:

- (1) The youth is 21 or 22 years of age; and
- (2) The youth was served by the aftercare services program prior to the age of 21; and
- (3) The youth has access to funding for postservices provided in contract that has not been fully expended for the contract year.

d. Definition of foster care. For purposes of this chapter, "foster care" is defined as 24-hour substitute care for a child who is placed away from the child's parents or guardians and for whom the

department or juvenile court services has placement and care responsibility through either a court order or voluntary agreement.

- (1) A placement may meet the definition of foster care regardless of whether:
 1. The placement is licensed and the state or a local agency makes payments for the child's care;
 2. Adoption subsidy payments are being made before the finalization of adoption; or
 3. There is federal matching of any payments made.
- (2) Foster care may include, but is not limited to, placement in:
 1. A foster family home; or
 2. A foster care group home; or
 3. An emergency shelter; or
 4. A preadoptive home; or
 5. The home of a relative or suitable person; or
 6. A psychiatric medical institution for children (PMIC).

187.2(4) Responsibility. The youth must:

- a. Actively take part in developing and participating in an individual self-sufficiency plan; and
- b. Indicate recognition and acceptance of personal responsibility in the transition toward self-sufficiency, which includes, but is not limited to, meeting with the self-sufficiency advocate regularly and as described in the youth's individual self-sufficiency plan, as described in subrule 187.3(2).

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

441—187.3(234) Services and supports provided. The aftercare services program shall provide the following services and supports to eligible youth:

187.3(1) Preservices. Planning, coordination of services, and trust-building activities may be provided to a youth placed out of home, as described in paragraph 187.2(3) "a," who is expected to participate in aftercare services at 18 years of age or older. The administrator may provide funds as described in paragraph 187.3(4) "a." However, funds provided to the youth in preservices will be deducted from available funds in the youth's first year of participation in core services.

187.3(2) Core services. Case management services shall be offered to youth, as described in paragraph 187.2(3) "b," at a safe and convenient location. Activities shall include, but not be limited to, all of the following:

a. Development of an individual self-sufficiency plan, based on an assessment of the youth's strengths and needs. Each core services participant shall have a plan to identify:

- (1) The youth's goals for achieving self-sufficiency;
- (2) The target date for reaching the goals; and
- (3) The tasks, responsible parties, time frames, and desired outcomes needed to reach the goals.

b. Services to develop a budget and money management skills training.

c. Services to assist the youth in establishing or reestablishing relationships with significant adults.

d. Services to facilitate the youth's access to community resources.

e. Life skills training, as identified in the youth's individual self-sufficiency plan. Life skills training shall include, but not be limited to, skills to help the youth in establishing and maintaining safe and stable housing; education goals; employment goals; health and health care coverage; and healthy relationships.

f. Additional case management activities necessary for youth to successfully transition to adulthood and as described in the individual self-sufficiency plan.

g. Individual face-to-face contact with the youth at the frequency defined in the youth's individual self-sufficiency plan and according to the youth's changing needs. If a youth is a resident of Iowa but is attending a postsecondary education program in another state, the program administrator or designee shall approve an alternative method for maintaining contact with the youth if and when it is a hardship for the youth to physically be in Iowa.

h. Ongoing assessment, including evaluation and coordination of the services, supports, and life skills training being provided to assist the youth in reaching self-sufficiency goals and to determine if

and what progress is being made. The case manager shall amend any goals, outcomes, tasks, responsible parties, and time frames in the plan along with services, supports, and life skills training provided as necessary to assist the youth in achieving self-sufficiency.

187.3(3) Postservices. Posttransition service may be provided to youth, as described in paragraph 187.2(3)“c,” and may include, but is not limited to, life skills training, periodic check-in, referrals to needed services, and limited payments to youth. Funds, limited to an annual per-participant amount identified in the contract, may be provided to a former aftercare services participant. Prior to receiving available funds, the youth is required to meet with the advocate and discuss the reason the youth is accessing funds and prior efforts to meet the need. The youth may also be asked to provide documentation of income.

187.3(4) Start-up allowance. When a youth between the ages of 17 and 21 is receiving or is expected to receive core services in accordance with subrule 187.3(2), and is actively participating in the program, the program administrator or designee may authorize and provide payment to a youth as described below:

a. The start-up allowance is intended to assist in covering the initial costs of establishing the youth’s living arrangement, such as by paying rental or utility deposits, purchasing food, or purchasing necessary household items.

b. The start-up allowance is limited to \$600 per youth.

187.3(5) Vendor payments. When a youth qualifies for core services in accordance with subrule 187.3(2), and is actively participating in the program, the program administrator or designee may authorize and provide payment to a youth as described below:

a. To receive a vendor payment, the youth must demonstrate that there are no other means to meet the needs that would be covered by the vendor payment. The youth shall contribute toward the cost of meeting the identified need, to the extent the youth is able. A youth receiving a preparation for adult living (PAL) stipend, preservices or postservices is not eligible for a vendor payment.

b. Vendor payments may include, but are not limited to:

- (1) Health care-related expenses;
- (2) Transportation assistance;
- (3) Costs related to employment and education;
- (4) Clothing; and
- (5) Room and board.

c. The amount available for a 12-month period of service shall not exceed \$1,200 per youth.

187.3(6) Preparation for adult living (PAL) stipend. When an eligible youth is actively participating in the program, the administrator or designee shall deliver the preparation for adult living program as described in Iowa Code section 234.46 and as follows:

a. To be eligible for the PAL stipend, the youth must:

- (1) Meet eligibility requirements in Iowa Code section 234.46 and rule 441—187.2(234); and
- (2) Have been placed out of home in paid foster care, the Iowa state training school, or a court-ordered Iowa juvenile detention center as identified by Iowa Code chapter 232 on the youth’s eighteenth birthday and have exited after having been in any combination of the same services in at least 6 of the 12 months before leaving placement; and
- (3) Be ineligible for voluntary foster care placement, due to one of the following:
 1. The youth has a high school diploma or equivalent, or
 2. The youth has reached 20 years of age, or
 3. The youth became eligible for aftercare services due to exiting the Iowa state training school or an Iowa detention center.

b. To be eligible for the PAL stipend, the youth must meet one or more of the following criteria:

- (1) Be enrolled in or actively pursuing enrollment in postsecondary education, a training program or work training; or
- (2) Be employed for 80 hours per month or be actively seeking that level of employment; or
- (3) Be attending an accredited school full-time pursuing a course of study leading to a high school diploma; or
- (4) Be attending an instructional program leading to a high school equivalency diploma.

c. The maximum monthly stipend shall be provided after completion of the youth's budget. The maximum amounts provided to a youth shall be stated in the contract and shall be based on program eligibility and guidelines, as follows:

(1) The monthly stipend shall be prorated based on the number of days of youth participation, for those entering and exiting the program during the month.

(2) When the monthly unearned income of the youth exceeds the overall maximum monthly stipend offered in the preparation for adult living program, the youth is not eligible for payments under subrule 187.3(4) unless unused startup funds remain.

(3) When the net earnings of the youth exceed the overall maximum monthly stipend offered in the preparation for adult living program, the monthly stipend shall be reduced by 50 cents for every dollar earned by the youth over the overall monthly maximum stipend.

(4) All earned and unearned income received by the youth during the 30 days before the determination shall be used to project future income. If the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(5) Nonrecurring lump-sum payments are excluded as income. Nonrecurring lump-sum payments include, but are not limited to, one-time payments received for such things as income tax refunds, rebates, credits, refunds of security deposits on rental property or utilities, and retroactive payments for past months' benefits such as social security, unemployment insurance, or public assistance.

(6) The youth shall timely report the beginning and ending of earned and unearned income. A report shall be considered timely when made within ten days from the receipt of income or the date income ended.

(7) When the youth timely reports a change in income, the youth's prospective eligibility and stipend amount for the following month shall be determined based on the change.

(8) Recoupment shall be made for any overpayment due to failure to timely report a change in income or for benefits paid during an administrative appeal if the department's action is ultimately upheld. Recoupment may be made through a reasonable reduction of any future stipends.

(9) Recoupment shall not be made when a youth timely reports a change in income and the change is timely acted upon, but the timely notice policy in rule 441—16.3(17A) requires that the action be delayed until the second calendar month following the month of change.

(10) The stipend may be paid to the youth, the foster family, or another payee other than a department employee. The payee shall be agreed upon by the parties involved and specified in the individual self-sufficiency plan, described in subrule 187.3(2).

(11) The maximum stipend may be based on the age of the youth.

187.3(7) Postservices allowance. Youth 21 or 22 years of age who previously received aftercare services may receive postservices funds if they meet all of the following criteria:

a. The youth is participating in postservices as described in subrule 187.3(3).

b. A budget discussion has been completed timely by the youth with a self-sufficiency advocate.

c. The need has been identified in the individual self-sufficiency plan.

d. The postservices funds approved for the youth have not exceeded \$600 for the previous 12-month period.

[ARC 4485C, IAB 6/5/19, effective 7/10/19; ARC 4973C, IAB 3/11/20, effective 4/15/20]

441—187.4(234) Termination of aftercare services.

187.4(1) A youth may be discharged from the aftercare services program for any of the following reasons:

a. The youth fails to follow individual self-sufficiency plan components and expectations as determined by the program administrator or designee.

b. The youth fails to meet regularly with the self-sufficiency advocate without good cause as determined by the program administrator or designee.

c. The youth voluntarily withdraws from the program.

d. The youth is no longer a resident of Iowa.

e. The youth reaches 23 years of age.

187.4(2) Aftercare services and supports may be terminated for up to six months as determined by the program administrator or designee when a youth intentionally physically threatens or injures program staff or an employee of an aftercare provider agency.

187.4(3) The PAL stipend may be terminated if the youth fails to meet work or education eligibility requirements for 30 consecutive days without good cause as determined by the program administrator or designee.

187.4(4) The PAL stipend may be terminated if the youth fails to maintain satisfactory progress as defined by the education or training program in which the youth is enrolled. A youth who is not making satisfactory progress may stay in the PAL program component of the aftercare services program by choosing the work option specified in subparagraph 187.3(6)“b”(2). A PAL stipend or allowance shall not be reinstated for at least 30 days if the stipend was terminated for the reason described in this subrule.

187.4(5) The youth intentionally misrepresents income or expenditures or spends funds in a manner inconsistent with their intended purpose. The program administrator may request receipts or acceptable evidence that funds went to the intended purpose.

187.4(6) There are insufficient funds.

187.4(7) Unless otherwise stated, a youth whose aftercare service is terminated in accordance with this rule may return to the program after the passing of at least 30 days. However, if the youth has received three or more notices of termination within a 12-month period, the youth may not return until at least three months have passed from the date of the third notification.

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

441—187.5(234) Waiting list. The program administrator or designee shall create a waiting list when all funds for the aftercare services program are committed for the fiscal year. Names shall be entered on the waiting list on a first-come, first-served basis once the youth is determined eligible. Due to funding, it may be necessary to create more than one waiting list.

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

441—187.6(234) Administration. The department may contract with another state agency or a private organization to perform the administrative and case management functions necessary to administer the aftercare services program. Agencies and organizations providing services or supports shall meet the standards in rules 441—108.2(238) through 441—108.6(238).

[ARC 4485C, IAB 6/5/19, effective 7/10/19]

These rules are intended to implement Iowa Code section 234.46 and Public Law 106-169, the Foster Care Independence Act of 1999.

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CHAPTER 67
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS,
AND ADULT DAY SERVICES

481—67.1(231B,231C,231D) Definitions. The following definitions apply to this chapter and to 481—Chapters 68, 69, and 70.

“Activities of daily living” means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting, and ambulation.

“Ambulatory” or *“ambulation”* means physically and cognitively able to walk without aid of another person.

“Applicable requirements” means Iowa Code chapters 135C, 231B, 231C, 231D, 235B, 235E, and 562A, this chapter, and 481—Chapters 68, 69, and 70, as applicable, and includes any other applicable administrative rules and provisions of the Iowa Code.

“Assignment” means the distribution of work for which each staff member, regardless of certification or licensure status, is responsible during a given work period and includes a nurse directing an individual to do something the individual is already authorized to do.

“Assistance” means aid to a tenant who self-directs or participates in a task or activity or who retains the mental or physical ability, or both, to participate in a task or activity. Cueing of the tenant regarding a particular task or activity shall be construed to mean the tenant has participated in the task or activity.

“Blueprint” means copies of all completed drawings, schedules, and specifications that have been certified, sealed, and signed by an Iowa-licensed architect or Iowa-licensed engineer of record. The department may allow electronic transfer of blueprints pursuant to policy.

“Certified staff” means certified nursing assistants (CNAs) and certified medication assistants (CMAs) employed by the program.

“Dementia” means an illness characterized by multiple cognitive deficits which represent a decline from previous levels of functioning and includes memory impairment and one or more of the following cognitive disturbances: aphasia, apraxia, agnosia, and disturbance in executive functioning.

“Department” means the department of inspections and appeals.

“Director” means the director of the department of inspections and appeals.

“Direct supervision” means the provision of guidance and oversight of a delegated nursing task through the physical presence of the licensed nurse to observe and direct certified and noncertified staff.

“Elope” means that a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

“Global Deterioration Scale” or *“GDS”* means the seven-stage scale for assessment of primary degenerative dementia developed by Dr. Barry Reisberg.

“Health care professional” means a physician, physician assistant, registered nurse or advanced registered nurse practitioner licensed in Iowa by the respective licensing board.

“Health-related care” means services provided by a registered nurse or a licensed practical nurse, on a part-time or intermittent basis, and services provided by other licensed health care professionals, on a part-time or intermittent basis. “Health-related care” includes nurse-delegated assistance.

“Human service professional” means an individual with a bachelor’s degree in a human service field including, but not limited to: human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of the required education. For example, an individual with an associate’s degree in a human service field and two years of experience in a human service field is a human service professional.

“Impaired decision-making ability” means a lack of capacity to make safe and prudent decisions regarding one’s own routine safety as determined by the program manager or nurse or means having a GDS score of five or above.

“Independent reviewer” means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

“Indirect supervision” means the provision of guidance and oversight of a delegated nursing task through means other than direct supervision, including written and verbal communication.

“Instrumental activities of daily living” means those activities that reflect the tenant’s ability to perform household and other tasks necessary to meet the tenant’s needs within the community, which may include but are not limited to shopping, housekeeping, chores, and traveling within the community.

“Medication setup” means assistance with various steps of medication administration to support a tenant’s autonomy, which may include but is not limited to routine prompting, cueing and reminding, opening containers or packaging at the direction of the tenant, reading instructions or other label information, or transferring medications from the original containers into suitable medication dispensing containers, reminder containers, or medication cups.

“Modification” means any addition to or change in physical dimensions or structure, except as incidental to the customary maintenance of the physical structure of the program’s facility.

“Monitoring” means an on-site evaluation of a program, a complaint investigation, or a program-reported incident investigation performed by the department to determine compliance with applicable requirements. A monitor who performs a monitoring for the department shall be a registered nurse, human service professional, or another person with program-related expertise.

“Noncertified staff” means unlicensed and uncertified personnel employed by the program.

“Nurse delegation” means the action of a registered nurse, advanced registered nurse practitioner, or licensed practical nurse to direct competent certified and noncertified staff to perform selected nursing tasks in selected situations. The decision of a nurse to delegate is based on the delegation process, including assessment, planning, implementation, supervision, and evaluation of the tenant, nursing tasks, personnel, and the situation. The nurse, as a licensed professional, retains accountability for the delegation process and the decision to delegate. Licensed practical nurses may delegate within the scope of their license with the supervision of a registered nurse.

“Occupancy agreement” or *“contractual agreement”* means a written contract entered into between a program and a tenant that clearly describes the rights and responsibilities of the program and the tenant and other information required by applicable requirements. An occupancy agreement may include a separate signed lease and signed service agreement.

“Part-time or intermittent care” means licensed nursing services and professional therapies that are provided in combination with nurse-delegated assistance with medications or activities of daily living and do not exceed 28 hours per week or, for adult day services, 4 hours per day.

“Personal care” means assistance with the essential activities of daily living which may include but are not limited to transferring, bathing, personal hygiene, dressing, and grooming that are essential to the health and welfare of a tenant.

“Physician extender” means nurse practitioners, clinical nurse specialists, and physician assistants.

“Preponderance of the evidence” means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true.

“Program” means one or more of the following, as applicable: an elder group home as defined in Iowa Code section 231B.1 and 481—Chapter 68, an assisted living program as defined in Iowa Code section 231C.1 and 481—Chapter 69, or adult day services as defined in Iowa Code section 231D.1 and 481—Chapter 70.

“Program staff” means all employees of the program, regardless of certification or licensure status.

“Qualified professional” means a facility plant engineer familiar with the type of program being provided, or a licensed plumbing, heating, cooling, or electrical contractor who furnishes regular service to such equipment.

“Recognized accrediting entity” means a nationally recognized accrediting entity that the department recognizes as having specific program standards equivalent to the program standards established by the department.

“Regulatory insufficiency” means a violation of an applicable requirement.

“Remodeling” means a modification of any part of an existing building, an addition of a new wing or floor to an existing building, or a conversion of an existing building.

“*Restraints*” means any chemical or manual method which restricts freedom of movement or normal access to one’s body or any physical or mechanical device, material or equipment which is attached or adjacent to the tenant’s body that the tenant cannot remove easily and which restricts freedom of movement or normal access to one’s body.

“*Routine*” means more often than not or on a regular customary basis.

“*Self-administration*” means a tenant’s taking personal responsibility for all phases of medication except for any component assigned to the program under medication setup, and may include the tenant’s use of an automatic pill dispenser.

“*Service plan*” means the document that defines all services necessary to meet the needs and preferences of a tenant, whether or not the services are provided by the program or other service providers.

“*Significant change*” means a major decline or improvement in the tenant’s status which does not normally resolve itself without further interventions by staff or by implementing standard disease-related clinical interventions that have an impact on the tenant’s mental, physical, or functional health status.

“*Substantial compliance*” means a level of compliance with applicable requirements such that any identified regulatory insufficiency poses no greater risk to tenant health or safety than the potential for causing minimal harm.

“*Tenant*” means an individual who receives services through a program. In the context of adult day services, “tenant” means a participant as defined in 481—Chapter 70.

“*Tenant advocate*” means the office of long-term care resident’s advocate established in Iowa Code section 231.42.

“*Tenant’s legal representative*” means a person appointed by the court to act on behalf of a tenant or a person acting pursuant to a power of attorney. In the context of adult day services, “tenant’s legal representative” means a participant’s legal representative as defined in 481—Chapter 70.

“*Waiver*” means action taken by the department that suspends in whole or in part the requirements or provisions of a rule.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1994C, IAB 5/27/15, effective 7/1/15; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program’s policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

67.2(1) The program’s policies and procedures on incident reports, at a minimum, shall include the following:

- a. The program shall have available incident report forms for use by program staff.
- b. An incident report shall be in detail and shall be provided on an incident report form.
- c. The person in charge at the time of the incident shall prepare and sign the report.
- d. The incident report shall include statements from individuals, if any, who witnessed the incident.
- e. All accidents or unusual occurrences within the program’s building or on the premises that affect tenants shall be reported as incidents.
- f. A copy of the completed incident report shall be kept on file on the program’s premises for a minimum of three years.

67.2(2) The program’s policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

- a. Reporting requirements for staff and employees, and
- b. Requirements that the victim and alleged abuser be separated.

67.2(3) The program shall follow the policies and procedures established by the program.
[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:

67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

67.3(2) To receive care, treatment and services which are adequate and appropriate.

67.3(3) To receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant shall be obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract.

67.3(4) To be free from mental and physical abuse.

67.3(5) To receive from the manager and staff of the program a reasonable response to all requests.

67.3(6) To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour.

67.3(7) To manage the tenant's own financial affairs unless a tenant's legal representative has been appointed for the purpose of managing the tenant's financial affairs.

67.3(8) To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.

67.3(9) To be free from restraints.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

67.4(1) Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury.

a. "Major injury" shall be defined as any injury which:

- (1) Results in death; or
- (2) Requires admission to a higher level of care for treatment, other than for observation; or
- (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis.

b. The following are not reportable accidents:

- (1) An ambulatory tenant who falls when neither the program nor its employees have culpability related to the fall, even if the tenant sustains a major injury; or
- (2) Spontaneous fractures; or
- (3) Hairline fractures.

67.4(2) When damage to the program is caused by a natural or other disaster.

67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30-day period.

67.4(4) When a tenant elopes from a program.

67.4(5) When a tenant attempts suicide, regardless of injury.

67.4(6) When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant.

67.4(7) When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal.)

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapters 235B and 235E, which require reporting of dependent adult abuse.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.5(231B,231C,231D) Medications.

67.5(1) If a program handles, stores, or administers controlled substances, the program shall be registered with the Iowa board of pharmacy as a care facility in accordance with 657—Chapter 10.

67.5(2) Each program shall follow its own written medication policy, which shall include the following:

- a. The program shall not prohibit a tenant from self-administering medications.
- b. A tenant shall self-administer medications unless:
 - (1) The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.
 - (2) The tenant delegates medication setup to someone other than the program.
 - (3) The program assumes partial control of medication setup at the direction of the tenant. The medication plan shall not be implemented by the program unless the program's registered nurse deems it appropriate under applicable requirements, including those in Iowa Code section 231C.16A and subrule 67.9(4). The program's registered nurse must agree to the medication plan.
- c. A tenant shall keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program. The service plan shall include the tenant's choice related to storage.
- d. When a tenant has delegated medication administration to the program, the program shall maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response. If the tenant discloses a medication list to the program in case of an emergency, the tenant remains responsible for the accuracy of the list.
- e. When medication setup is delegated to the program by the tenant, staff via nurse delegation may transfer medications from the original prescription containers or unit dosing into medication reminder boxes or medication cups.
- f. When medications are administered traditionally by the program:
 - (1) The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician assistant (PA) in accordance with 645—Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).
 - (2) Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.
 - (3) The program shall maintain a list of each tenant's medications and document the medications administered.
 - (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant.
- g. Narcotics protocol, including destruction and reconciliation, shall be determined by the program's registered nurse.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 1050C, IAB 10/2/13, effective 11/6/13; ARC 2463C, IAB 3/16/16, effective 4/20/16; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—67.6(231B,231C,231D) Another business or activity located in a program.

67.6(1) A business or activity serving persons other than tenants of a program is allowed in a designated part of the physical structure in which the program is located if the other business or activity meets the requirements of applicable state and federal codes, administrative rules, and federal regulations.

67.6(2) A business or activity conducted in the designated part of the physical structure in which the program is located shall not interfere with the use of the program by tenants or with services provided to tenants or disturb tenants.

67.6(3) A business or activity conducted in the designated part of the physical structure in which the program is located shall not reduce access, space, services, or staff available to tenants or necessary to meet the needs of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program.

67.7(1) *Time-limited waiver.* Upon receipt of a program's request for waiver of the criteria for retention of a tenant, the department may grant a waiver of the criteria under applicable requirements for a time-limited basis. Absent extenuating circumstances, a waiver of the criteria for retention of a tenant is limited to a period of six months or less.

67.7(2) *Waiver petition procedures.* The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant:

a. A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.

b. The department shall respond in writing to a waiver request within 15 working days of receipt of all required documentation. In consultation with the program, the department may take an additional 15 working days to report its determination regarding the waiver request.

c. The program shall provide to the department within 5 working days written notification of any changes in the condition of the tenant as described in the approved waiver request.

67.7(3) *Factors for consideration for waiver of criteria for retention of a tenant.* In addition to the criteria established in Iowa Code subsection 17A.9A(2), the following factors may be demonstrative in determining whether the criteria for issuance of a waiver have been met.

a. It is the informed choice of the tenant or the tenant's legal representative, if applicable, to remain in the program;

b. The program is able to provide the staff necessary to meet the tenant's service needs in addition to the service needs of the other tenants;

c. The department shall only issue a waiver if the waiver will not jeopardize the health, safety, security or welfare of the tenant, program staff, or other tenants; and

d. The tenant has been diagnosed with a terminal illness and has been admitted to hospice, and the tenant exceeds the criteria for retention and admission for a temporary period of less than six months. A terminal diagnosis means the tenant is within six months of the end of life.

67.7(4) *Conditional waiver.* A conditional waiver may be granted contingent upon the department's receipt of additional information or performance of monitoring.

a. If a waiver has been in effect for six months, a monitoring shall be conducted to determine whether the tenant meets the criteria to continue on a waiver.

b. The department may seek additional information during the period to determine if a waiver should be granted.

67.7(5) *Appeals.* The denial of a waiver request may be appealed by the program pursuant to Iowa Code chapter 17A.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—67.8(231B,231C,231D) All other waiver requests. Waiver requests relating to topics other than retention of a tenant in a program shall be filed in accordance with 481—Chapter 6.

[ARC 8174B, IAB 9/23/09, effective 1/1/10]

481—67.9(231B,231C,231D) Staffing.

67.9(1) *Number of staff.* A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

67.9(2) *Emergency procedures.* All program staff shall be able to implement the accident, fire safety, and emergency procedures.

67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.

67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

e. The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff.

f. Services shall be provided to tenants in accordance with the training provided.

g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.

h. In the absence of the program's registered nurse due to vacation or other temporary circumstances, the nurse assuming the duties of the program's registered nurse shall have access to staff training in relation to tenant needs.

67.9(5) Prohibited services. A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption.

67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 0961C, IAB 8/21/13, effective 9/25/13; ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—67.10(17A,231B,231C,231D) Monitoring.

67.10(1) Frequency of monitoring. The department shall monitor a certified program at least once during the program's certification period.

67.10(2) Accessibility of records and program areas. All records and areas of the program deemed necessary to determine compliance with the applicable requirements shall be accessible to the department for purposes of monitoring.

67.10(3) Standard for determining whether a regulatory insufficiency exists. The department shall use a preponderance-of-the-evidence standard when determining whether a regulatory insufficiency exists. A preponderance-of-the-evidence standard does not require that the monitor shall have personally witnessed the alleged violation.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure.

67.11(1) Complaints. The process for filing a complaint is as follows:

a. Any person with concerns regarding the operation or service delivery of a program may file a complaint with the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; by use of the complaint hotline, 1-877-686-0027; by facsimile sent to (515)281-7106; or through the website address: dia-hfd.iowa.gov/DIA_HFD/Home.do.

b. When the nature of the complaint is outside the department's authority, the department shall forward the complaint or refer the complainant, if known, to the appropriate investigatory entity.

c. The complainant shall include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the program or tenant; and the reason for the complaint. The complainant's name shall be confidential information and shall not be released by the department. The department shall act on anonymous complaints unless the department determines that the complaint is intended to harass the program. If the department, upon preliminary review, determines that the complaint is intended as harassment or is without reasonable basis, the department may dismiss the complaint.

67.11(2) *Program-reported incident reports.* When the program is required pursuant to applicable requirements to report an incident, the program shall make the report to the department via:

a. The web-based reporting tool accessible from the following Internet site, dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Complaints" tab;

b. Mail by sending the complaint to the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083;

c. The complaint hotline, 1-877-686-0027; or

d. Facsimile sent to (515)281-7106.

67.11(3) *Time frames for investigation of complaints or program-reported incident reports.* Upon receipt of a complaint or program-reported incident report made in accordance with this rule, the department shall conduct a preliminary review of the complaint or report to determine if a potential regulatory insufficiency has occurred. If a potential regulatory insufficiency exists, the department shall institute a monitoring of the program within the following time frames: within 2 working days of receipt of the complaint or incident report if there is the possibility of immediate danger, including that the potential regulatory insufficiency has caused or is likely to cause serious injury, harm, impairment, or death to a resident; or within 20 working days of receipt of the complaint or incident report if the potential regulatory insufficiency has caused or may cause harm that negatively impacts a tenant's mental, physical, or psychosocial status or function and is of such consequence to the tenant's well-being that a rapid response is warranted; or within 45 working days of receipt of the complaint or incident report for any other complaint or incident investigation, including a potential regulatory insufficiency that may have caused harm of limited consequence and does not significantly impair the tenant's mental, physical, or psychosocial status or function.

67.11(4) *Standard for determining whether a complaint is substantiated.* The department shall apply a preponderance-of-the-evidence standard in determining whether or not a complaint or program-reported incident report is substantiated.

67.11(5) *Notification of program and complainant.* The department shall notify the program and, if known, the complainant of the final report regarding the complaint investigation.

67.11(6) *Notification of accrediting entity.* In addition, for any credible report of alleged improper or inappropriate conduct or conditions within an accredited program, the department shall notify the accrediting entity by the most expeditious means possible of any actions taken by the department with respect to certification enforcement.

67.11(7) *Notification of complainant when complaint not investigated.* The department shall notify the complainant, if known, if the department does not investigate a complaint. The reasons for not investigating the complaint shall be included in the notification.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—67.12(17A,231B,231D) Adult day services and elder group homes—preliminary report, plan of correction and request for reconsideration. Rescinded ARC 1701C, IAB 10/29/14, effective 1/1/15.

481—67.13(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction.

67.13(1) *Exit interview.* The department shall provide an exit interview in person or by telephone at the conclusion of a monitoring, during which the department shall inform the program's representative of all issues and areas of concern related to insufficient practices. A second exit interview shall be provided if the department identifies additional issues or areas of concern. The program shall have 2 working days from the date of the exit interview to submit additional or rebuttal information to the department.

67.13(2) *Final report.* The department shall issue the final report of a monitoring within 10 working days after completion of the on-site monitoring or the receipt by the department of additional or rebuttal information, by personal service, electronically or by certified mail. The department shall issue a final report regarding a monitoring whether or not any regulatory insufficiency is found.

67.13(3) *Plan of correction.* Within 10 working days following receipt of the final report, the program shall submit a plan of correction to the department.

a. Contents of plan. The plan of correction shall include:

(1) Elements detailing how the program will correct each regulatory insufficiency, including at the system level;

(2) The date by which the regulatory insufficiency will be corrected;

(3) What measures will be taken to ensure the problem does not recur;

(4) How the program plans to monitor performance to ensure compliance; and

(5) Any other required information.

The date by which the regulatory insufficiency will be corrected shall not exceed 30 days from receipt of the final report pursuant to subrule 67.13(2) without approval of the department.

b. Review of plan. The department shall review the plan of correction within 10 working days. The department may request additional information or suggest revisions to the plan.

67.13(4) *Monitoring revisit.* The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1701C, IAB 10/29/14, effective 1/1/15; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—67.14(17A,231B,231C,231D,85GA,HF2365) Response to final report. Within 20 working days after the issuance of the final report and assessment of civil penalty, if any, the program shall respond in the following manner.

67.14(1) *If not contesting final report.* If the program does not desire to seek an informal conference or contest the final report and civil penalty, if assessed, the program shall remit to the department of inspections and appeals the amount of the civil penalty, if assessed. If a program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if the requirements of subrule 67.17(5) are met.

67.14(2) *If contesting the final report.* If the program desires to contest the final report and civil penalty, if assessed, the program shall notify the department of inspections and appeals in writing that it desires to contest the final report and civil penalty and shall do one of the following:

a. Request an informal conference with an independent reviewer pursuant to subrule 67.14(3); or

b. Request a contested case hearing in the manner provided by Iowa Code chapter 17A for contested cases.

67.14(3) *Informal conference.*

a. Request for informal conference. The request for an informal conference must be in writing and include the following:

(1) Identification of the regulatory insufficiency(ies) being disputed;

- (2) The type of informal conference requested: face-to-face or telephone conference; and
- (3) A request for monitor's notes for the regulatory insufficiencies being disputed, if desired.

b. Submission of documentation. The program shall submit the following within 10 working days from the date of the program's written request for an informal conference:

- (1) The names of those who will be attending the informal conference, including legal counsel; and
- (2) Documentation supporting the program's position. The program must highlight or use some other means to identify written information pertinent to the disputed regulatory insufficiency(ies).

Supporting documentation that is not submitted with the request for an informal conference will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the program has shown good cause, the independent reviewer shall consider what circumstances kept the program from submitting the supporting documentation within the required time frame.

c. Face-to-face or telephone conference. A face-to-face or telephone conference, if requested, will be scheduled to occur within 10 working days of the receipt of the written request, all supporting documentation and the plan of correction required by subrule 67.13(3).

- (1) Failure to submit supporting documentation will not delay scheduling.

(2) The conference will be scheduled for one hour. The program will informally present information and explanation concerning the contested regulatory insufficiency(ies). The department will have time to respond to the program's presentation. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested by the independent reviewer during the informal conference, the program will have 2 working days to deliver the additional materials to the independent reviewer.

(4) When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the program may be given one opportunity to reschedule the face-to-face conference.

d. Results. The results of the informal conference will generally be sent within 10 working days after the date of the informal conference, or within 10 working days after the receipt of additional information, if requested.

(1) The independent reviewer may affirm or may modify or dismiss the regulatory insufficiency and civil penalty. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the regulatory insufficiency.

(2) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) final report if changes result from the informal conference.

(3) The program must submit to the department a new plan of correction for the amended or corrected report within 10 calendar days from the date of the letter conveying the results of the conference.

(4) If the informal conference results in dismissal of a regulatory insufficiency for which a civil penalty was assessed, the corresponding civil penalty will be rescinded.

67.14(4) Procedure after informal conference. After the conclusion of an informal conference:

a. If the program does not desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, remit to the department of inspections and appeals the civil penalty, if assessed.

b. If the program does desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, notify the department of inspections and appeals in writing that it desires to formally contest the final report.

67.14(5) Contested case hearings. Contested case hearings shall be conducted by the department's administrative hearings division pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 1701C, IAB 10/29/14, effective 1/1/15; ARC 2142C, IAB 9/16/15, effective 10/21/15; ARC 3523C, IAB 12/20/17, effective 1/24/18]

481—67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate.

67.15(1) Notice and request for hearing. The denial, suspension or revocation of a certificate shall be effected by delivering to the applicant or certificate holder by restricted certified mail or by personal service a notice setting forth the particular reasons for such actions. A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice, unless the applicant or certificate holder gives the department written notice requesting a hearing within the 30-day period. If a timely request for hearing is made, the notice shall be deemed suspended pending the outcome of the hearing, unless subrule 67.15(3) or 67.15(4) applies. If an enforcement action has been implemented immediately in accordance with subrule 67.15(3) or 67.15(4), the enforcement action remains in effect regardless of a request for hearing.

67.15(2) Hearings. Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 9.

67.15(3) Immediate suspension of a certificate. When the department finds that an imminent danger to the health or safety of tenants of a program exists which requires action on an emergency basis, the department may direct removal of all tenants from the program and suspend the certificate or require additional remedies to ensure the ongoing safety of the program's tenants prior to a hearing.

67.15(4) Immediate imposition of enforcement action. When the department finds that an imminent danger to the health or safety of tenants exists which requires action on an emergency basis, the department may immediately impose a conditional certificate and accompanying conditions upon the program in lieu of immediate suspension of the certificate and removal of the tenants from the program if the department finds that tenants' health and safety would still be protected. The program may request a hearing, but the immediate enforcement action remains in effect regardless of the request for hearing. [ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 3523C, IAB 12/20/17, effective 1/24/18]

481—67.16(17A,231B,231C,231D) Conditional certification.

67.16(1) Conditional certification. In lieu of denial, suspension or revocation of a certificate, the department may issue a conditional certificate for a period of up to one year. Notwithstanding subrule 67.15(4), a conditional certificate shall be issued only when regulatory insufficiencies pose no greater risk to tenant health or safety than the potential for causing minimal harm.

a. The department shall specify the reasons for the conditional certificate in the notice issuing the conditional certificate.

b. The department may place conditions upon a certificate, such as requiring additional training; restriction of the program from accepting additional tenants for a period of time; or any other action or combination of actions deemed appropriate by the department.

c. Failure by the program to adhere to the plan of correction or conditions placed on the certificate may result in suspension or revocation of the conditional certification and may result in further enforcement action as available under applicable requirements.

d. A program must be in substantial compliance with applicable requirements before the removal of a conditional certificate by the department. Prior to lifting a conditional certificate, the department may conduct a monitoring to verify substantial compliance. Once the program is in substantial compliance with applicable requirements, the department shall lift the conditional certificate.

67.16(2) Appeal of conditional certificate. A written request for hearing must be received by the department within 30 days after the mailing or service of notice. The conditional certificate shall not be suspended pending the hearing. Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 9. [ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 3523C, IAB 12/20/17, effective 1/24/18]

481—67.17(17A,231B,231C,231D) Civil penalties.

67.17(1) When civil penalties may be issued. Civil penalties may be issued when the director finds that any of the following has occurred:

a. A program that does not comply with applicable requirements and the noncompliance results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than \$10,000.

b. A program that continues to fail or refuses to comply with applicable requirements within prescribed time frames established by the department or approved by the department in the program's plan of correction and the noncompliance has a direct relationship to the health, safety, or security of tenants may be assessed a civil penalty of not more than \$5,000.

c. A program that prevents, interferes with or attempts to impede in any way any duly authorized representative of the department in the lawful enforcement of applicable requirements may be assessed a civil penalty of not more than \$1,000.

d. A program that discriminates or retaliates in any way against a tenant, tenant's family, or an employee of the program who has initiated or participated in any proceeding authorized by Iowa Code chapter 231B, 231C or 231D and the corresponding administrative rules may be assessed a civil penalty of not more than \$5,000.

67.17(2) Duplicate civil penalties prohibited. The department shall not impose duplicate civil penalties on a program for the same set of facts and circumstances.

67.17(3) Factors in determining the amount of a civil penalty. The department shall consider the following factors when determining the amount of a civil penalty:

a. The frequency and length of time the regulatory insufficiency occurred (i.e., whether the regulatory insufficiency was an isolated or a widespread occurrence, practice, or condition);

b. The past history of the program as it relates to the nature of the regulatory insufficiency (the department shall not consider more than the current certification period and the immediately previous certification period);

c. The culpability of the program as it relates to the reasons the regulatory insufficiency occurred;

d. The extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;

e. The relationship of the regulatory insufficiency to any other types of regulatory insufficiencies which have occurred in the program;

f. The actions of the program after the occurrence of the regulatory insufficiency, including when corrective measures, if any, were implemented and whether the program notified the director as required;

g. The accuracy and extent of records kept by the program which relate to the regulatory insufficiency, and the availability of such records to the department;

h. The rights of tenants to make informed decisions;

i. Whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

67.17(4) Civil penalties due. The civil penalty shall be paid to the department within 30 days following the program's receipt of the final report and demand letter. The program may appeal in accordance with rule 481—67.14(17A,231C,85GA,SF394). If the program appeals, the civil penalty shall be deemed suspended until the appeal is resolved.

67.17(5) Reduction of civil penalty amount by 35 percent. If an assisted living program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if both of the following requirements are met:

a. The program does not request a formal hearing pursuant to rule 481—67.14(17A,231C,85GA,SF394), or withdraws its request for formal hearing within 30 calendar days of the date that the civil penalty was assessed; and

b. The civil penalty is paid and payment is received by the department within 30 calendar days of receipt of the final report.

[ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—67.18(17A,231B,231C,231D) Judicial review. Judicial review shall be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 3523C, IAB 12/20/17, effective 1/24/18]

481—67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.

67.19(1) Definitions. The following definitions apply for the purposes of this rule.

“*Background check*” or “*record check*” means criminal history, child abuse and dependent adult abuse record checks.

“*Direct services*” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a program for a very limited purpose, who are not in the program on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

“*Employed in a program*” or “*employment within a program*” means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An employee of an assisted living program certified under Iowa Code chapter 231C, if the employee provides direct services to consumers;
2. An employee of an elder group home certified under Iowa Code chapter 231B, if the employee provides direct services to consumers;
3. An employee of an adult day services program certified under Iowa Code chapter 231D, if the employee provides direct services to consumers.

“*Employee*” means any individual who is paid, either by the program or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

“*Evaluation*” means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person’s being prohibited from employment in a program.

“*Indirect services*” means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

“*Program,*” for purposes of this rule, means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An assisted living program certified under Iowa Code chapter 231C;
2. An elder group home certified under Iowa Code chapter 231B; and
3. An adult day services program certified under Iowa Code chapter 231D.

67.19(2) *Explanation of “crime.”* For purposes of this rule, the term “crime” does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

67.19(3) *Requirements for employer prior to employing an individual.* Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

a. Informing the prospective employee. A program shall ask each person seeking employment by the program, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions in this state or any other state?” The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

b. Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person’s maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services.

c. If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the program.

d. If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult

abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.

e. Employment pending evaluation. The program may employ a person for not more than 60 calendar days pending the completion of the evaluation by the department of human services if all of the following apply. The 60-day period begins on the first day of the person's employment.

(1) The person is being considered for employment other than employment involving the operation of a motor vehicle;

(2) The person does not have a record of founded child or dependent adult abuse;

(3) The person has been convicted of a crime that is a simple misdemeanor offense under Iowa Code section 123.47 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2, subsection 1; and

(4) The program has requested an evaluation to determine whether the crime warrants prohibition of the person's employment.

67.19(4) Validity of background check results. The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.

67.19(5) Employment prohibition. A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services.

67.19(6) Transfer of an employee to another program owned or operated by the same person. If an employee transfers from one program to another program owned or operated by the same person, without a lapse in employment, the program is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

67.19(7) Transfer of ownership of a program. If the ownership of a program is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The program may continue to employ such employee pending the performance of the background check and any related evaluation.

67.19(8) Change of employment—person with criminal or abuse record—exception to record check evaluation requirements. A person with a criminal or abuse record who is or was employed by a certified program and is hired by another certified program shall be subject to the background check.

a. A reevaluation of the latest record check is not required, and the person may commence employment with the other certified program if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person's criminal or abuse record and concluded the record did not warrant prohibition of the person's employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) 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;

(4) Any restrictions placed on the person's employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person's subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it to the subsequent employer, or the previous employer provides 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, a current record check evaluation shall be performed.

b. For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of

nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

c. The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

d. The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 67.19(8) "a" may be authorized.

67.19(9) *Employee notification of criminal convictions or founded abuse after employment.* If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

a. The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) "c" and "d."

c. The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

d. A person who is required by this subrule to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

e. The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

67.19(10) *Program receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the program receives credible information, as determined by the program, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 67.19(9), the program shall take the following actions:

a. The program shall act to verify credible information within seven calendar days of receipt. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.19(3) "c" and "d."

67.19(11) *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 231B.2(1), 231C.3(1), 231D.2(2), and 135C.33 and 2013 Iowa Acts, Senate File 347.

[ARC 0963C, IAB 8/21/13, effective 9/25/13; ARC 1547C, IAB 7/23/14, effective 8/27/14]

481—67.20(17A,231C,231D) Emergency removal of tenants. If the department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the department shall use the following procedures to ensure a safe and orderly transfer.

67.20(1) The department shall notify the department of human services, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:

- a. To alert them to the need to transfer tenants from a program;
- b. To request assistance in identifying alternative programs or other appropriate settings; and
- c. To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.

67.20(2) The department shall notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.20(1).

67.20(3) The department, in conjunction with other agencies as necessary and appropriate, shall proceed with the transfer of tenants.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.21(231C) Nursing assistant work credit.

67.21(1) A person who is certified as a nursing assistant, including a medication aide, and who is supervised by a registered nurse may submit information to the department to obtain credit toward maintaining certification for working in a program. A program may add an employee to the direct care worker registry by calling (515)281-4077 or by registering through the health facilities division website at dia-hfd.iowa.gov/DIA_HFD/Home.do, under the “Documents” tab.

67.21(2) A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may be obtained by telephone at (515)281-4077 or via the health facilities division website at dia-hfd.iowa.gov/DIA_HFD/Home.do, under the “Documents” tab.

67.21(3) A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at (515)281-4077 or via the health facilities division website at dia-hfd.iowa.gov/DIA_HFD/Home.do, under the “Documents” tab.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14]

481—67.22(231B,231C,231D) Public or confidential information.

67.22(1) Public information.

a. *Public disclosure of findings.* The program shall post a notice stating that copies of the final report resulting from a monitoring are available via the department’s website at dia-hfd.iowa.gov/DIA_HFD/Home.do. The program shall post the notice in a prominent location on the premises of the program. Copies shall also be available upon request from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0083; telephone (515)281-6325.

b. *Open records.* The following records are open records available for inspection:

- (1) Certification applications, certification status, and accompanying materials;
- (2) Final findings of state monitorings, including a monitoring that results from a complaint or program-reported incident;
- (3) Reports from the state fire marshal;
- (4) Plans of correction submitted by a program;
- (5) Official notices of certification sanctions, including enforcement actions;
- (6) Findings of fact, conclusions of law, decisions and orders issued pursuant to rules 481—67.10(17A,231B,231C,231D) and 481—67.13(17A,231B, 231C,231D);
- (7) Waivers, including the department’s approval and denial letter and any letter requesting the waiver.

67.22(2) Confidential information. Confidential information includes the following:

a. Information that does not comprise a final report resulting from a monitoring, complaint investigation, or program-reported incident investigation. Information which does not comprise a final report may be made public in a legal proceeding concerning a denial, suspension or revocation of certification;

b. Names of all complainants;

c. Names of tenants of a program, identifying medical information, copies of documentation appointing a legal representative, and the address of anyone other than an owner or operator; and

d. Social security numbers or employer identification numbers (EIN).

67.22(3) *Redaction of confidential information.* If a record normally open for inspection contains confidential information, the confidential information shall be redacted before the records are provided for inspection.

[ARC 8174B, IAB 9/23/09, effective 1/1/10; ARC 1055C, IAB 10/2/13, effective 1/1/14; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—67.23(231B,231C,231D) Training related to Alzheimer’s disease and similar forms of irreversible dementia. Rescinded ARC 1547C, IAB 7/23/14, effective 8/27/14.

These rules are intended to implement Iowa Code chapters 231B, 231C as amended by 2013 Iowa Acts, Senate File 394, and 231D.

[Filed ARC 8174B (Notice ARC 7877B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]

[Filed ARC 0961C (Notice ARC 0809C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 0963C (Notice ARC 0808C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

[Filed ARC 1055C (Notice ARC 0941C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]

[Filed ARC 1547C (Notice ARC 1472C, IAB 5/28/14), IAB 7/23/14, effective 8/27/14]

[Filed ARC 1701C (Notice ARC 1616C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]

[Filed ARC 1994C (Notice ARC 1942C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[Filed ARC 2142C (Notice ARC 2067C, IAB 7/22/15), IAB 9/16/15, effective 10/21/15]

[Filed ARC 2463C (Notice ARC 2200C, IAB 10/14/15), IAB 3/16/16, effective 4/20/16]

[Filed ARC 3523C (Notice ARC 3407C, IAB 10/25/17), IAB 12/20/17, effective 1/24/18]

[Filed ARC 4976C (Notice ARC 4867C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

CHAPTER 68
ELDER GROUP HOMES

481—68.1(231B) Definitions. In addition to the definitions in 481—Chapter 67 and Iowa Code chapter 231B, the following definitions apply.

“*Applicable requirements*” means Iowa Code chapter 231B, this chapter and 481—Chapter 67 and includes any other applicable administrative rules and provisions of the Iowa Code.

“*Change of ownership*” means the purchase, transfer, assignment or lease of a certified elder group home and includes a change in the management company responsible for the day-to-day operation of the program, if the management company is ultimately responsible for any enforcement action taken by the department.

“*Committee*” means a resident advocate committee established by 321—Chapter 9.

“*Elder*” means a person 60 years of age or older.

“*Elder group home*” or “*EGH*” means a single-family residence that is operated by a person who is providing room, board, and personal care and may provide health-related services to three through five elders who are not related to the person providing the service within the third degree of consanguinity or affinity and that is staffed by an on-site manager 24 hours per day seven days per week.

“*Household occupant*” means a tenant and all others who reside in the EGH.

“*In the proximate area*” means located within a five minutes or less response time.

“*Maximal assistance with activities of daily living*” means routine total dependence on staff for the performance of a minimum of four activities of daily living for a period that exceeds 21 days.

“*Medically unstable*” means that a tenant has a condition or conditions:

1. Indicating physiological frailty as determined by the program’s staff in consultation with a physician or physician extender;
2. Resulting in two or more significant hospitalizations within a consecutive three-month period for more than observation; and
3. Requiring supervision by a registered nurse more than once a week of the tenant for more than 21 days.

For example, a tenant who has a condition such as congestive heart failure which results in two or more significant hospitalizations during a quarter and which requires that the tenant receive frequent supervision may be considered medically unstable.

“*On-site manager*” means the person on duty responsible for direct supervision or provision of tenant care. The on-site manager may be any household occupant over 18 years of age, except a tenant, who is qualified to perform the necessary duties.

“*Personal care provider*” means an individual who, in return for remuneration, assists with the essential activities of daily living which the tenant can perform personally only with difficulty.

“*Program*” means an elder group home.

“*Unmanageable incontinence*” means a condition that requires staff provision of total care for an incontinent tenant who lacks the ability to assist in bladder or bowel continence care.

“*Unmanageable verbal abuse*” means repeated verbalizations against tenants or staff that persist despite all interventions and that negatively affect the program. “Unmanageable verbal abuse” includes but is not limited to threats, frequent use of profane language, or unwelcome sexually oriented remarks.

“*Usable floor space*” means open floor space that is not under fixtures, furniture or other barriers and is available for walking or wheelchair use.

[ARC 8175B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—68.2(231B) Program certification and posting requirements.

68.2(1) Certification requirements. A program may obtain certification by meeting all applicable requirements. For the purpose of these rules, certification is equivalent to licensure.

68.2(2) Posting requirements. A program’s current certificate shall be visibly displayed within the designated operation area of the program. In addition, the latest monitoring report, state fire marshal

report, and food establishment inspections report issued pursuant to Iowa Code chapter 137F shall be made available to the public by the program upon request.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.3(231B) Certification—application process.

68.3(1) The applicant shall complete an application packet obtained from the department. Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do; by mail from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.

68.3(2) The applicant shall submit one copy of the completed application and all supporting documentation to the department at the above address at least 90 calendar days prior to the expected date of beginning operation.

68.3(3) The appropriate fee as stated in Iowa Code section 231B.17 shall accompany each application and be payable by check or money order to the Department of Inspections and Appeals. Fees are nonrefundable.

68.3(4) The department shall consider the application when all supporting documents and fees are received.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.4(231B) Certification—application content. An application for certification or recertification of an EGH shall include the following:

68.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

- a. The real estate owner or lessor;
- b. The lessee; and
- c. The management company responsible for the day-to-day operation of the program.

The program shall notify the department of any changes in the list no later than ten working days after the effective date of the change.

68.4(2) A statement disclosing whether the individuals listed in subrule 68.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

68.4(3) A statement disclosing whether any of the individuals listed in subrule 68.4(1) have or have had an ownership interest in an assisted living program, adult day services program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.

68.4(4) The policy and procedure for evaluation of each tenant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each tenant shall be included.

68.4(5) The policy and procedure for service plans.

68.4(6) The policy and procedure for addressing medication needs of tenants.

68.4(7) The policy and procedure for accidents and emergency response.

68.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.

68.4(9) The policy and procedure for transportation.

68.4(10) The policy and procedure for staffing and training.

68.4(11) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.

68.4(12) The policy and procedure for managing risk and upholding tenant autonomy when tenant decision making results in poor outcomes for the tenant or others.

68.4(13) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).

68.4(14) The tenant occupancy agreement and all attachments.

68.4(15) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

68.4(16) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

68.4(17) The fee set forth in Iowa Code section 231B.17.

[ARC 8175B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—68.5(231B) Initial certification process.

68.5(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.

68.5(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept tenants.

68.5(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.

68.5(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.

68.5(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

68.5(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

68.5(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.6(231B) Expiration of program certification.

68.6(1) Unless conditionally issued, suspended or revoked, certification of a program shall expire at the end of the time period specified on the certificate.

68.6(2) The department shall send recertification application materials to each program at least 120 calendar days prior to expiration of the program's certification.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.7(231B) Recertification process. To obtain recertification, a program shall:

68.7(1) Submit one copy of the completed application, including the information required in rule 481—68.4(231B), associated documentation, and the recertification fee as listed in Iowa Code section 231B.17 to the department at the address stated in subrule 68.3(1) at least 90 calendar days prior to the expiration of the program's certification. The program need not submit policies and procedures that have been previously submitted to the department and remain unchanged. The program shall provide a list of the policies and procedures that have been previously submitted and are not being resubmitted.

68.7(2) Submit additional documentation that each of the following has been inspected and found to be maintained in conformance with the manufacturer's recommendations and nationally recognized standards: heating system, cooling system, water heater, electrical system, plumbing, sewage system, artificial lighting, and ventilation system; and, if located on site, garbage disposal, kitchen appliances, washing machines and dryers, and elevators.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.8(231B) Notification of recertification.

68.8(1) The department shall review the application and associated documentation and fees. If the application is incomplete, the department shall contact the program to request the additional information. After all finalized documentation is received, including state fire marshal approval, the department shall determine the program's compliance with applicable requirements.

68.8(2) The department shall conduct a monitoring of the program between 60 and 90 days prior to expiration of the program's certification.

68.8(3) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.

68.8(4) If no regulatory insufficiency is identified as a result of the monitoring, the department shall issue a report of the findings with the final recertification decision.

68.8(5) If the decision is to recertify, the department shall issue the program a two-year certification effective from the date of the expiration of the previous certification.

68.8(6) If the decision is to deny recertification, the department shall issue a notice of denial and provide the program the opportunity for a hearing pursuant to rule 481—67.13(17A,231B,231C,231D).

68.8(7) If the department is unable to recertify a program through no fault of the program, the department shall issue to the program a time-limited extension of certification of no longer than one year.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.9(231B) Listing of all certified programs. The department shall maintain a list of all certified programs, which is available online at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Entities Book" tab.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.10(231B) Change of ownership—notification to the department.

68.10(1) Certification, unless conditionally issued, suspended or revoked, may be transferable. If the program's certification has been conditionally issued, the department must approve a change of ownership prior to the transfer of the certification.

68.10(2) In order to transfer certification, the applicant must:

a. Meet the requirements of the rules, regulations and standards contained in Iowa Code chapter 231B and 481—Chapter 67 and this chapter; and

b. At least 30 days prior to the change of ownership of the program, make application on forms provided by the department.

68.10(3) The department may conduct a monitoring within 90 days following a change in the program's ownership to ensure that the program complies with applicable requirements. If a regulatory insufficiency is found, the department shall take any necessary enforcement action authorized by applicable requirements.

[ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—68.11(231B) Cessation of program operation.

68.11(1) If a certified program ceases operation, which includes seeking decertification, at any time prior to expiration of the program's certification, the program shall submit the certificate to the department. The program shall provide, at least 90 days in advance of cessation, which includes seeking decertification, unless there is some type of emergency, written notification to the department and the tenant advocate of the date on which the program will cease operation, which includes seeking decertification.

68.11(2) If a certified program plans to cease operation, which includes seeking decertification, at the time the program's certification expires, the program shall provide written notice of this fact to the department and the tenant advocate at least 90 days prior to expiration of the certification.

68.11(3) At the time a program decides to cease operation, which includes seeking decertification, the program shall submit a plan to the department and make arrangements for the safe and orderly transfer or transition of all tenants within the 90-day period specified by subrule 68.11(2).

68.11(4) The department may conduct a monitoring during the 90-day period to ensure the safety of tenants during the transfer process or transition process.

68.11(5) The department may conduct an on-site visit to verify that the program has ceased operation as a certified program in accordance with the notice provided by the program.

68.11(6) When a program ceases operation, which includes seeking decertification, tenant advocates shall be allowed by the program to privately meet with tenants to provide education and service options. [ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.12(231B) Occupancy agreement.

68.12(1) The occupancy agreement shall be in 12-point type or larger, shall be written in plain language using commonly understood terms and shall be easy for the tenant or the tenant's legal representative to understand.

68.12(2) In addition to the requirements of Iowa Code section 231B.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments:

- a. The telephone number for filing a complaint with the department.
- b. The telephone number for the office of the tenant advocate.
- c. The telephone number for reporting dependent adult abuse.
- d. A copy of the program's statement on tenants' rights.
- e. A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency.
- f. A copy of the program's admission and transfer criteria.

68.12(3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.

68.12(4) A copy of the occupancy agreement shall be provided to the tenant or the tenant's legal representative, if any, and a copy shall be kept by the program.

68.12(5) A copy of the most current occupancy agreement shall be made available to the general public upon request. The basic marketing material shall include a statement that a copy of the occupancy agreement is available to all persons upon request. [ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.13(231B) Evaluation of tenant.

68.13(1) *Evaluation prior to occupancy.* A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and becoming a household occupant to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional.

68.13(2) *Evaluation within 30 days of occupancy and with significant change.* A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. [ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.14(231B) Criteria for admission and retention of tenants.

68.14(1) *Persons who may not be admitted or retained.* A program shall not knowingly admit or retain a tenant who:

- a. Is bed-bound; or
- b. Requires routine, one-person assistance with standing, transfer or evacuation; or
- c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:
 - (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression; or
 - (2) Displays behavior that places another tenant at risk; or
- d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or
- e. Is under the age of 18; or
- f. Requires more than part-time or intermittent health-related care; or
- g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or
- h. Is medically unstable; or
- i. Requires maximal assistance with activities of daily living; or
- j. Is physically or mentally unable to immediately and without aid of another travel a normal path to safety, including the ascent and descent of stairs from the tenant's bedroom or bathroom.

68.14(2) *Disclosure of additional occupancy and transfer criteria.* A program may have additional occupancy or transfer criteria if the criteria are disclosed in the written occupancy agreement prior to the tenant's occupancy.

68.14(3) *Assistance with transfer from the program.* A program shall provide assistance to a tenant and the tenant's legal representative, if applicable, to ensure a safe and orderly transfer from the program when the tenant exceeds the program's criteria for admission and retention.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.15(231B) Involuntary transfer from the program.

68.15(1) *Program initiation of transfer.* If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:

a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the tenant advocate.

b. The program shall immediately provide to the tenant advocate, by certified mail, a copy of the notification and notify the tenant's treating physician, if any.

c. Pursuant to statute, the tenant advocate shall offer the notified tenant or tenant's legal representative assistance with the program's internal appeal process. The tenant or tenant's legal representative is not required to accept the assistance of the tenant advocate.

d. If, following the internal appeal process, the program upholds the transfer decision, the tenant or tenant's legal representative may utilize other remedies authorized by law to contest the transfer.

68.15(2) *Transfer pursuant to results of monitoring or complaint or program-reported incident investigation by the department.* If one or more tenants are identified as exceeding the admission and retention criteria for tenants and need to be transferred as a result of a monitoring or a complaint or program-reported incident investigation conducted by the department, the following procedures shall apply:

a. *Notification of the program.* Within 20 working days of the monitoring or complaint or program-reported incident investigation, the department shall notify the program, in writing, of the identification of any tenant who exceeds admission and retention criteria.

b. *Notification of others.* Each identified tenant, the tenant's legal representative, if applicable, and other providers of services to the tenant shall be notified of their opportunity to provide responses including: specific input, written comment, information, and documentation directly addressing any agreement or disagreement with the identification. All responses shall be provided to the department within 10 days of receipt of the notice.

c. Program agreement with the department's finding. If the program agrees with the department's finding and the program begins involuntary transfer proceedings, the program's internal appeal process in subrule 68.15(1) shall be utilized for appeals.

d. Program disagreement with the department's finding. If the program does not agree with the department's finding that the tenant exceeds admission and retention criteria, the program may collect and submit all responses to the department, including those from other interested parties. In the program's response, the program shall identify the tenant, list the known responses from others, and note the program's agreement or disagreement with the responses from others. The program's response shall be submitted to the department within 10 working days of the receipt of the notice. Submission of a response does not eliminate the applicable requirements including submission of a plan of correction under 481—subrule 67.10(5). Other persons may also submit information directly to the department.

(1) Consideration of response. Within 10 working days of receipt of the program's response for each identified tenant, the department shall consider the response and make a final finding regarding the continued retention of a tenant.

(2) Amending the regulatory insufficiency. If the department's determination is to amend the regulatory insufficiency based on the response, the department shall modify the report of findings.

(3) Retaining regulatory insufficiency. If the department retains the regulatory insufficiency, the department shall review the plan of correction in accordance with this chapter and 481—Chapter 67. The department shall notify the program of the opportunity to appeal the report findings as they relate to the admission and retention decision. In addition, the department shall provide to the tenant or the tenant's legal representative the contact information for the tenant advocate. A copy of the final report shall also be sent to the tenant advocate.

(4) Effect of the filing of an appeal. If an appeal is filed, the tenant who exceeds admission and retention criteria shall be allowed to continue living in the EGH until all administrative appeals have been exhausted. Appeals filed that relate to the tenant's exceeding admission and retention criteria shall be heard within 30 days of receipt, and appropriate services to meet the tenant's needs shall be provided during that period of time.

(5) Request for waiver of criteria for retention of a tenant in a program. To allow a tenant to remain in the program, the program may request a waiver of criteria for retention of a tenant pursuant to rule 481—67.7(231B,231C,231D) from the department within 10 working days of the receipt of the report. [ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.16(231B) Tenant documents.

68.16(1) Documentation for each tenant shall be maintained by the program and shall include:

a. An occupancy record including the tenant's name, birth date, and home address; identification numbers; date of beginning participation; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;

b. Application forms;

c. The initial evaluations and updates;

d. A nutritional assessment as necessary;

e. The initial individual service plan and updates;

f. Signed authorizations for permission to release medical information, photographs, or other media information as necessary;

g. A signed authorization for the tenant to receive emergency medical care as necessary;

h. A signed managed risk policy and signed managed risk consensus agreements, if any;

i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;

j. Medication lists, which shall be maintained in conformance with 481—paragraph 67.5(2) "d";

k. Advance health care directives as applicable;

l. A complete copy of the tenant's occupancy agreement, including any updates;

m. A written acknowledgment that the tenant or the tenant's legal representative, if applicable, has been fully informed of the tenant's rights;

n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;

o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record);

p. A copy of waivers of admission or retention criteria, if any;

q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs); and

r. Authorizations for the release of information, if any.

68.16(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant.

68.16(3) All records shall be protected from loss, damage and unauthorized use.

[ARC 8175B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—68.17(231B) Service plans.

68.17(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 68.13(1) and 68.13(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

68.17(2) Prior to the tenant's signing the occupancy agreement and becoming a household occupant, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.

68.17(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.

a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.

b. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.

c. If a significant change relates to a recurring or chronic condition, a previous evaluation and service plan of the recurring condition may be utilized without new signatures being obtained. For example, with chronic exacerbation of a urinary tract infection, nurse review is adequate to institute the previously written evaluation and service plan.

68.17(4) The service plan shall be individualized and shall indicate, at a minimum:

a. The tenant's identified needs and preferences for assistance;

b. Any services and care to be provided pursuant to the occupancy agreement;

c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; and

d. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the elder group home occupancy.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.18(231B) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

68.18(1) To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and

68.18(2) To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program; and

68.18(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; and

68.18(4) To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—68.17(231B), showing the time, date and signature.

NOTE: Refer to Table A at the end of this chapter. If the program does not provide personal or health-related care to a tenant, nurse review is not required.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.19(231B) Staffing. In addition to the general staffing requirements in rule 481—67.9 (231B,231C,231D), the following requirements apply to staffing in programs.

68.19(1) The program shall be staffed by an on-site manager 24 hours per day, seven days per week.

68.19(2) Personal care providers shall have completed, at minimum, a home care aide training program that meets the requirements and criteria established in 641—Chapter 80.

68.19(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.

68.19(4) Personal care providers and nursing staff may be employed by the program or obtained through a contract with a home health agency or other service provider. Regardless of the source, the staff must meet all applicable requirements.

68.19(5) The program shall notify the department in writing within ten business days of a change in the program's manager.

[ARC 8175B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—68.20(231B) Managed risk policy and managed risk consensus agreements. The program shall have a managed risk policy. The managed risk policy shall be provided to the tenant along with the occupancy agreement. The managed risk policy shall include the following:

68.20(1) An acknowledgment of the shared responsibility for identifying and meeting the needs of the tenant and the process for managing risk and for upholding tenant autonomy when tenant decision making results in poor outcomes for the tenant or others; and

68.20(2) A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the tenant's file.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.21(231B) Transportation. When transportation services are provided directly or under contract with the program:

68.21(1) The vehicle shall be accessible and appropriate to the tenants who use it, with consideration for any physical disabilities and impairments.

68.21(2) Every tenant transported shall have a seat in the vehicle, except for a tenant who remains in a wheelchair during transport.

68.21(3) Vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers.

68.21(4) Wheelchairs shall be secured when the vehicle is in motion.

68.21(5) During loading and unloading of a tenant, the driver shall be in the proximate area of the tenants in a vehicle.

68.21(6) The driver shall have a valid and appropriate Iowa driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.22(231B) Identification of veteran's benefit eligibility.

68.22(1) Within 30 days of a tenant's participation in an elder group home that receives reimbursement through the medical assistance program under Iowa Code chapter 249A, the program shall ask the tenant or the tenant's personal representative whether the tenant is a veteran or whether the tenant is the spouse, widow, or dependent of a veteran and shall document the response.

68.22(2) If the program determines that the tenant may be a veteran or the spouse, widow, or dependent of a veteran, the program shall report the tenant's name along with the name of the veteran, if applicable, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. When appropriate, the program may also report such information to the Iowa department of human services.

68.22(3) If a tenant is eligible for benefits through the U.S. Department of Veterans Affairs or other third-party payor, the program first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.23(231B) Resident advocate committees. Resident advocate committees for EGHs shall be governed by 321—Chapter 9 unless otherwise required in this chapter.

68.23(1) *Committee placement.* A resident advocate committee shall be established by the commission on aging for each program certified in accordance with this chapter.

68.23(2) *Committee visitations.* The committee shall visit the program assigned to it within one month of the admission of the first tenant as well as a minimum of once and maximum of four times annually thereafter.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.24(231B) Life safety—emergency policies and procedures and structural safety requirements.

68.24(1) The program shall submit to the department and follow written emergency policies and procedures, which shall include the following:

- a. An emergency plan, which shall include procedures for natural disasters (identify where the plan is located for easy reference);
- b. Fire safety procedures;
- c. Other general or personal emergency procedures;
- d. Provisions for amending or revising the emergency plan;
- e. Provisions for periodic training of all employees;
- f. Procedures for fire drills;
- g. Regulations regarding smoking;
- h. Monitoring and testing of smoke-control systems;
- i. Tenant evacuation procedures; and
- j. Procedures for reporting and documentation.

68.24(2) The program's structure and procedures and the facility in which a program is located shall meet the requirements adopted for elder group homes in administrative rules promulgated by the state fire marshal. Approval of the state fire marshal indicating that the building is in compliance with these requirements is necessary for certification of a program.

68.24(3) The program shall have the means to control the maximum temperature of water at sources accessible by a tenant to prevent scalding and shall control the maximum water temperature for tenants with cognitive impairment or dementia or at a tenant's request.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.25(231B) Structural standards.

68.25(1) The EGH shall be safe, sanitary, well-ventilated, and properly lighted, heated, and cooled; and shall comply with all applicable state and local housing ordinances for family residences and with fire safety rules promulgated by the state fire marshal.

68.25(2) In addition to meeting the requirements in subrule 68.25(1), the EGH shall meet the following standards:

a. General.

(1) The home, furnishings and fixtures shall be clean, in good repair and appropriate for the tenants.

(2) Stairways shall have handrails of a circumference, length, texture, strength and stability that can reasonably be expected to provide tenant support.

(3) A functioning light shall be provided in each room, stairway and exit; all light bulbs shall be protected from breakage or removal with appropriate covers.

(4) The yard, fire exits and exterior steps shall be kept free of obstructions and shall be accessible and appropriate to the condition of the tenants.

(5) There shall be at least 150 square feet of common living space and sufficient furniture in the home to accommodate the recreational and socialization needs of all the tenants at one time; common space shall not be located in the basement or garage, unless such space was constructed for that purpose. Additional common living space may be required if wheelchairs, walkers or other durable medical equipment is to be accommodated. For an EGH constructed or remodeled after July 1, 2005, there shall be 300 square feet of usable floor space.

(6) Interior and exterior doorways used by tenants shall be wide enough to accommodate wheelchairs and walkers if tenants with impaired mobility are in residence.

(7) Hot and cold water at each tub, shower, and sink shall be in sufficient supply to meet the needs of the tenants and staff.

(8) Grab bars shall be present for each toilet, tub and shower. Access to toilet and bathing facilities shall be barrier-free. Toilet and bathing facilities shall provide individual privacy.

(9) A telephone shall be available and accessible for tenants' use in a manner that allows for privacy for all calls.

b. Safety.

(1) All combustion appliances shall be used and maintained properly and shall be inspected annually by a qualified technician for carbon monoxide emissions and any other hazards to health and safety;

(2) Extension cord wiring shall not be used in place of permanent electrical fixtures or outlets.

c. Sanitation requirements.

(1) A public water supply shall be utilized if available. If a nonmunicipal water source is used, the owner or on-site manager must show documentation from the state laboratory that the water supply is potable and is tested as required by the rules of the environmental protection commission of the department of natural resources.

(2) Septic tanks or other nonmunicipal wastewater disposal systems shall be in good working order and shall comply with state and local regulations for wastewater treatment.

(3) Garbage and refuse shall be suitably stored and disposed of by a sanitation company providing service in the area.

(4) If laundry service is provided, soiled linens and clothing shall be stored in containers in an area separate from food storage, kitchen and dining areas.

(5) Sanitation for household pets and other domestic animals shall be adequate to prevent health and safety hazards.

(6) There shall be adequate control of insects and rodents.

(7) Reasonable and prudent precautions for infection control shall be taken, including washing hands and exposed portions of arms with soap and hot water immediately before engaging in food preparation and meal service and before and after providing personal care.

(8) There shall be at least one toilet and one sink for every four household occupants. A minimum of one sink and toilet is required on each floor occupied by tenants. A sink shall be located near each toilet. For an EGH constructed or remodeled after July 1, 2005, there shall be at least one toilet and one sink for every two household occupants, with a minimum of one toilet and one sink on each floor occupied by tenants.

(9) At least one tub or shower is required for each six household occupants. For an EGH constructed or remodeled after July 1, 2005, there shall be at least one tub or one shower for every four household occupants.

d. Bedroom requirements.

(1) Each tenant bedroom shall:

1. Have a door that opens directly to a hallway or common use area without passage through another bedroom or common bathroom;

2. Be adequately ventilated, heated, cooled and lighted;

3. Have at least 70 square feet of usable floor space, excluding any area where a sloped ceiling does not allow a person to stand upright. For an EGH constructed or remodeled after July 1, 2005, each tenant bedroom shall have at least 100 square feet of usable floor space;

4. Provide individual privacy and be occupied by one tenant, unless an alternative arrangement is agreed to in the occupancy agreement by the tenant or the tenant's legal representative;

5. Be on ground level for tenants with impaired mobility;

6. Be in sufficiently close proximity to the on-site manager to ensure that tenants are able to alert the on-site manager to nighttime needs or emergencies, or be equipped with a call system.

(2) Owners, operators, on-site managers, their family members, and personal care providers shall not use as bedrooms areas that are designated as living areas or as tenant bedrooms;

(3) Common living space and tenant bedrooms shall not be used for storage areas.

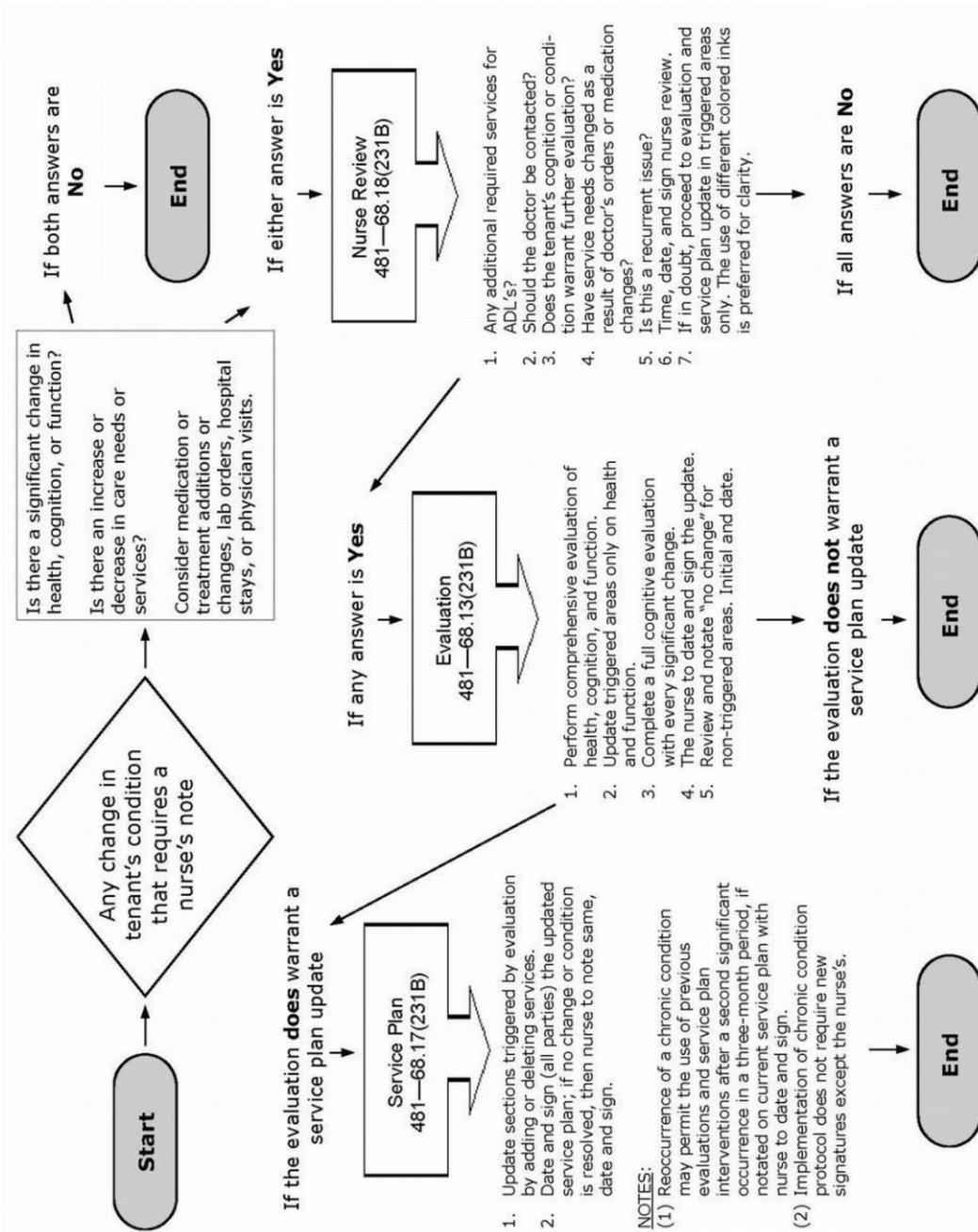
[ARC 8175B, IAB 9/23/09, effective 1/1/10]

481—68.26(231B) Landlord and tenant Act. Iowa Code chapter 562A, the uniform residential landlord and tenant Act, shall apply to all EGHs under this chapter.

[ARC 8175B, IAB 9/23/09, effective 1/1/10]

These rules are intended to implement Iowa Code chapter 231B.

Table A



[Filed ARC 8175B (Notice ARC 7960B, IAB 7/15/09), IAB 9/23/09, effective 1/1/10]
 [Filed ARC 1927C (Notice ARC 1860C, IAB 2/4/15), IAB 4/1/15, effective 5/6/15]
 [Filed ARC 4976C (Notice ARC 4867C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

CHAPTER 69
ASSISTED LIVING PROGRAMS

481—69.1(231C) Definitions. In addition to the definitions in 481—Chapter 67 and Iowa Code chapter 231C, the following definitions apply.

“*Accredited*” means that the program has received accreditation from an accreditation entity recognized in subrule 69.14(1).

“*Applicable requirements*” means Iowa Code chapter 231C, this chapter, and 481—Chapter 67 and includes any other applicable administrative rules and provisions of the Iowa Code.

“*Assisted living*” or “*program*” means provision of housing with services, which may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living, to three or more tenants in a physical structure which provides a homelike environment. “Assisted living” also includes encouragement of family involvement, tenant self-direction, and tenant participation in decisions that emphasize choice, dignity, privacy, individuality, shared risk, and independence. “Assisted living” includes the provision of housing and assistance with instrumental activities of daily living only if personal care or health-related care is also included. “Assisted living” includes 24 hours per day response staff to meet scheduled and unscheduled or unpredictable needs in a manner that promotes maximum dignity and independence and provides supervision, safety, and security.

“*CARF*” means the Commission on Accreditation of Rehabilitation Facilities.

“*Change of ownership*” means the purchase, transfer, assignment or lease of a certified assisted living program and includes a change in the management company responsible for the day-to-day operation of the program, if the management company is ultimately responsible for any enforcement action taken by the department.

“*Cognitive disorder*” means a disorder characterized by cognitive dysfunction presumed to be the result of illness that does not meet the criteria for dementia, delirium, or amnesic disorder.

“*Dementia-specific assisted living program*” means an assisted living program certified under this chapter that:

1. Serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale, or
2. Serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale, or
3. Holds itself out as providing specialized care for persons with dementia, such as Alzheimer’s disease, in a dedicated setting.

“*Dwelling unit*” means a single unit which provides complete, independent living facilities for one or more persons, including permanent provisions for living, sleeping and sanitation, and which may include permanent provisions for eating and cooking. “Sanitation” for purposes of this definition means bathroom fixtures as required by this chapter.

“*In the proximate area*” means located within a five minutes or less response time.

“*Maximal assistance with activities of daily living*” means routine total dependence on staff for the performance of a minimum of four activities of daily living for a period that exceeds 21 days.

“*Medically unstable*” means that a tenant has a condition or conditions:

1. Indicating physiological frailty as determined by the program’s staff in consultation with a physician or physician extender;
2. Resulting in three or more significant hospitalizations within a consecutive three-month period for more than observation; and
3. Requiring frequent supervision of the tenant for more than 21 days by a registered nurse.

For example, a tenant who has a condition such as congestive heart failure which results in three or more significant hospitalizations during a quarter and which requires that the tenant receive frequent supervision may be considered medically unstable.

“*Nonaccredited*” means that the program has been certified under the provisions of this chapter but has not received accreditation from an accreditation entity recognized in subrule 69.14(1).

“*Unmanageable incontinence*” means a condition that requires staff provision of total care for an incontinent tenant who lacks the ability to assist in bladder or bowel continence care.

“*Unmanageable verbal abuse*” means repeated verbalizations against tenants or staff that persist despite all interventions and that negatively affect the program. “Unmanageable verbal abuse” includes but is not limited to threats, frequent use of profane language, or unwelcome sexually oriented remarks. [ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.

69.2(1) Posting requirements. A program’s current certificate shall be visibly displayed within the designated operation area of the program. In addition, the latest monitoring report, state fire marshal report, and food establishment inspections report issued pursuant to Iowa Code chapter 137F shall be made available to the public by the program upon request.

69.2(2) Dementia-specific programs and door alarms. If a program meets the definition of a dementia-specific assisted living program during two sequential certification monitorings, the program shall meet all requirements for a dementia-specific program, including the requirements set forth in rule 481—69.30(231C), subrules 69.29(2) and 69.29(4), paragraph 69.35(1) “d,” and subrules 69.32(2) and 69.32(3), which include the requirements relating to door alarms and specialized locking systems, within 90 days of receiving the final report from the second sequential certification monitoring.

69.2(3) Dementia-specific program by definition. If a program meets the definition of a dementia-specific assisted living program during two sequential certification monitorings based on the number of tenants served who have dementia between Stages 4 and 7 on the Global Deterioration Scale, the program shall be deemed a dementia-specific program by definition. If the number of tenants served who have dementia between Stages 4 and 7 on the Global Deterioration Scale goes below that which is required by the definition of dementia-specific program at any time after the program has been deemed dementia-specific by definition and the program is not holding itself out as providing dementia care in a specialized setting, the program will no longer be considered dementia-specific.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.3(231C) Certification of a nonaccredited program—application process.

69.3(1) The applicant shall complete an application packet obtained from the department. Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do; by mail from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.

69.3(2) The applicant shall submit one copy of the completed application and all supporting documentation to the department at the above address at least 90 calendar days prior to the expected date of beginning operation.

69.3(3) The appropriate fee as stated in Iowa Code section 231C.18 shall accompany each application and be payable by check or money order to the Department of Inspections and Appeals. Fees are nonrefundable.

69.3(4) The department shall consider the application when all supporting documents and fees are received.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.4(231C) Nonaccredited program—application content. An application for certification or recertification of a nonaccredited program shall include the following:

69.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

- a. The real estate owner or lessor;
- b. The lessee; and
- c. The management company responsible for the day-to-day operation of the program.

The program shall notify the department of any changes in the list no later than ten working days after the effective date of the change.

69.4(2) A statement disclosing whether the individuals listed in subrule 69.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

69.4(3) A statement disclosing whether any of the individuals listed in subrule 69.4(1) have or have had an ownership interest in an assisted living program, adult day services program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure, certification, or registration or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.

69.4(4) The policy and procedure for evaluation of each tenant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each tenant shall be included.

69.4(5) The policy and procedure for service plans.

69.4(6) The policy and procedure for addressing medication needs of tenants.

69.4(7) The policy and procedure for accidents and emergency response, including provisions related to head injuries.

69.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.

69.4(9) The policy and procedure for activities.

69.4(10) The policy and procedure for transportation.

69.4(11) The policy and procedure for staffing and training.

69.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.

69.4(13) The policy and procedure for managing risk and upholding tenant autonomy when tenant decision making results in poor outcomes for the tenant or others.

69.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).

69.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 69.32(2).

69.4(16) The tenant occupancy agreement and all attachments.

69.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

69.4(18) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

69.4(19) The fee set forth in Iowa Code section 231C.18.

69.4(20) The policy and procedure for addressing sexual relationships between tenants and staff, and between tenants with dementia greater than Stage 5 on the Global Deterioration Scale.

69.4(21) The policy and procedure for extraordinary lifesaving measures, such as cardiopulmonary resuscitation (CPR).

69.4(22) The program shall follow the policies and procedures established.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15; ARC 2463C, IAB 3/16/16, effective 4/20/16; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.5(231C) Initial certification process for a nonaccredited program.

69.5(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether or not the proposed program meets applicable requirements.

69.5(2) If, based upon the review of the complete application including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept tenants.

69.5(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.

69.5(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.

69.5(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

69.5(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

69.5(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.6(231C) Expiration of the certification of a nonaccredited program.

69.6(1) Unless conditionally issued, suspended or revoked, certification of a program shall expire at the end of the time period specified on the certificate.

69.6(2) The department shall send recertification application materials to each program at least 120 calendar days prior to expiration of the program's certification.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.7(231C) Recertification process for a nonaccredited program. To obtain recertification, a program shall:

69.7(1) Submit one copy of the completed application, including the information required in rule 481—69.4(231C), associated documentation, and the recertification fee as listed in Iowa Code section 231C.18 to the department at the address stated in subrule 69.3(1) at least 90 calendar days prior to the expiration of the program's certification. The program need not submit policies and procedures that have been previously submitted to the department and remain unchanged. The program shall provide a list of the policies and procedures that have been previously submitted and are not being resubmitted.

69.7(2) Submit additional documentation that each of the following has been inspected by a qualified professional and found to be maintained in conformance with the manufacturer's recommendations and nationally recognized standards: heating system, cooling system, water heater, electrical system, plumbing, sewage system, artificial lighting, and ventilation system; and, if located on site, garbage disposal, kitchen appliances, washing machines and dryers, and elevators.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.8(231C) Notification of recertification for a nonaccredited program.

69.8(1) The department shall review the application and associated documentation and fees. If the application is incomplete, the department shall contact the program to request the additional information. After all finalized documentation is received, including state fire marshal approval, the department shall determine the program's compliance with applicable requirements.

69.8(2) The department shall conduct a monitoring of the program between 60 and 90 days prior to expiration of the program's certification.

69.8(3) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.

69.8(4) If no regulatory insufficiency is identified as a result of the monitoring, the department shall issue a report of the findings with the final recertification decision.

69.8(5) If the decision is to recertify, the department shall issue the program a two-year certification effective from the date of the expiration of the previous certification.

69.8(6) If the decision is to deny recertification, the department shall issue a notice of denial and provide the program the opportunity for a hearing pursuant to rule 481—67.13(17A,231B,231C,231D).

69.8(7) If the department is unable to recertify a program through no fault of the program, the department shall issue to the program a time-limited extension of certification of no longer than one year.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.9(231C) Certification or recertification of an accredited program—application process.

69.9(1) An applicant for certification or recertification of a program accredited by a recognized accrediting entity shall:

a. Submit a completed application packet obtained from the department. Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do; by mail from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.

b. Submit a copy of the current accreditation outcome from the recognized accrediting entity.

c. Apply for certification or recertification within 90 calendar days following verification of compliance with life safety requirements pursuant to this chapter.

d. Maintain compliance with the state fire marshal division's requirements.

e. Submit the appropriate fees as set forth in Iowa Code section 231C.18.

69.9(2) The department shall not consider an application until it is complete and includes all supporting documentation and the appropriate fees.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.10(231C) Certification or recertification of an accredited program—application content. An application for certification or recertification of an accredited program shall include the following:

69.10(1) A list that includes the names, addresses and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

a. The real estate owner or lessor;

b. The lessee; and

c. The management company responsible for the day-to-day operation of the program.

The program shall notify the department of any changes in the list no later than ten working days after the effective date of the change.

69.10(2) A statement disclosing whether the individuals listed in subrule 69.10(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

69.10(3) A statement disclosing whether any of the individuals listed in subrule 69.10(1) have or have had an ownership interest in a program, adult day services program, elder group home, home health agency, licensed health care facility as defined under Iowa Code section 135C.1, or licensed hospital as defined under Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.

69.10(4) A copy of the current accreditation outcome from the recognized accrediting entity.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—69.11(231C) Initial certification process for an accredited program.

69.11(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether or not the accredited program meets applicable requirements and whether or not certification will be issued.

69.11(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

69.11(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

69.11(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.12(231C) Recertification process for an accredited program.

69.12(1) The department shall send recertification application materials to each program at least 120 calendar days prior to expiration of the program's certification.

69.12(2) To obtain recertification, an accredited program shall submit one copy of the completed application, associated documentation, and the administrative fee as stated in Iowa Code section 231C.18 to the department at the address stated in subrule 69.9(1) at least 90 calendar days prior to the expiration of the program's certification.

69.12(3) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine the program's compliance with applicable requirements and make a recertification decision.

69.12(4) The department shall notify the accredited program within 10 working days of the final recertification decision.

a. If the decision is to recertify, a full certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

b. If the decision is to deny recertification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

69.12(5) If the department is unable to recertify a program through no fault of the program, the department shall issue to the program a time-limited extension of certification of no longer than one year.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.13(231C) Listing of all certified programs. The department shall maintain a list of all certified programs, which is available online at https://dia-hfd.iowa.gov/DIA_HFD/Home.do under the "Entities Book" tab.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.14(231C) Recognized accrediting entity.

69.14(1) The department designates CARF as a recognized accrediting entity for programs.

69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.

69.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.

69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.15(231C) Requirements for an accredited program. Each accredited program that is certified by the department shall:

69.15(1) Provide the department a copy of all survey reports including outcomes, quality improvement plans and annual conformance to quality reports generated or received, as applicable, within ten working days of receipt of the reports.

69.15(2) Notify the department by the most expeditious means possible of all credible reports of alleged improper or inappropriate conduct or conditions within the program and any actions taken by the accrediting entity with respect thereto.

69.15(3) Notify the department immediately of the expiration, suspension, revocation or other loss of the program's accreditation.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.16(231C) Maintenance of program accreditation.

69.16(1) An accredited program shall continue to be recognized for certification by the department if both of the following requirements are met:

a. The program complies with the requirements outlined in rule 481—69.15(231C).

b. The program maintains its voluntary accreditation status for the duration of the time-limited certification period.

69.16(2) A program that does not maintain its voluntary accreditation status must become certified by the department prior to any lapse in accreditation.

69.16(3) A program that does not maintain its voluntary accreditation status and is not certified by the department prior to any lapse in voluntary accreditation shall cease operation as a program.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.17(231C) Change of ownership—notification to the department.

69.17(1) Certification, unless conditionally issued, suspended or revoked, may be transferable. If the program's certification has been conditionally issued, the department must approve a change of ownership prior to the transfer of the certification.

69.17(2) In order to transfer certification, the applicant must:

a. Meet the requirements of the rules, regulations and standards contained in Iowa Code chapter 231C and 481—Chapter 67 and this chapter; and

b. At least 30 days prior to the change of ownership of the program, make application on forms provided by the department.

69.17(3) The department may conduct a monitoring within 90 days following a change in the program's ownership to ensure that the program complies with applicable requirements. If a regulatory insufficiency is found, the department shall take any necessary enforcement action authorized by applicable requirements.

[ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—69.18(231C) Plan reviews of a building for a new program.

69.18(1) Before a building is constructed or remodeled for use in a new program, the state fire marshal division of the department of public safety shall review the blueprints for compliance with requirements pursuant to this chapter. Construction or remodeling includes new construction, remodeling of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building.

69.18(2) A program applicant shall submit blueprints wet-sealed by an Iowa-licensed architect or Iowa-licensed engineer and the blueprint plan review fee as stated in Iowa Code section 231C.18 to the Department of Public Safety, State Fire Marshal Division, 215 E. 7th Street, Third Floor, Des Moines, Iowa 50319.

69.18(3) Failure to submit the blueprint plan review fee with the blueprints shall result in delay of the blueprint plan review until the fee is received.

69.18(4) The state fire marshal division of the department of public safety shall review the blueprints and notify the Iowa-licensed architect or Iowa-licensed engineer in writing regarding the status of compliance with requirements.

69.18(5) The Iowa-licensed architect or Iowa-licensed engineer shall respond to the state fire marshal division of the department of public safety to state how any noncompliance will be resolved.

69.18(6) Upon final notification by the state fire marshal division of the department of public safety that the blueprints meet the state fire marshal division's requirements, construction or remodeling of the building may commence.

69.18(7) The state fire marshal division of the department of public safety shall schedule an on-site visit of the building site with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the construction or remodeling process to ensure compliance with the approved blueprints. Any noncompliance must be resolved prior to approval for certification.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.19(231C) Plan review prior to the remodeling of a building for a certified program.

69.19(1) Before a building for a certified program is remodeled, the state fire marshal division of the department of public safety shall review the blueprints for compliance with requirements set forth in rule 481—69.35(231C). Remodeling includes modification of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building.

69.19(2) A certified program shall submit blueprints wet-sealed by an Iowa-licensed architect or Iowa-licensed engineer and the blueprint plan review fee as stated in Iowa Code section 231C.18 to the Department of Public Safety, State Fire Marshal Division, 215 E. 7th Street, Third Floor, Des Moines, Iowa 50319.

69.19(3) Failure to submit the blueprint plan review fee with the blueprints shall result in delay of the blueprint plan review until the fee is received.

69.19(4) Upon final notification by the state fire marshal division of the department of public safety that the blueprints meet structural and life safety requirements, remodeling of the building may commence.

69.19(5) The state fire marshal division of the department of public safety shall schedule an on-site visit of the building with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the remodeling process to ensure compliance with the approved blueprints. Any noncompliance must be resolved prior to approval for continued certification or recertification of the program.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.20(231C) Cessation of program operation.

69.20(1) If a certified program ceases operation, which includes seeking decertification, at any time prior to expiration of the program's certification, the program shall submit the certificate to the department. At least 90 days in advance of cessation or decertification, the program shall provide to the department and the office of long-term care ombudsman written notification of the date on which the program will cease operation or decertify.

69.20(2) If a certified program plans to cease operation, which includes seeking decertification, at the time the program's certification expires, the program shall provide written notice of this fact to the department and the office of long-term care ombudsman at least 90 days prior to expiration of the certification.

69.20(3) At the time a program decides to cease operation, which includes seeking decertification, the program shall submit a plan to the department and make arrangements for the safe and orderly transfer or transition of all tenants within the 90-day period specified by subrule 69.20(2).

69.20(4) The department may conduct a monitoring during the 90-day period to ensure the safety of tenants during the transfer process or transition process.

69.20(5) The department may conduct an on-site visit to verify that the program has ceased operation as a certified program in accordance with the notice provided by the program.

69.20(6) When a program ceases operation, which includes seeking decertification, representatives from the office of long-term care ombudsman shall be allowed by the program to privately meet with tenants to provide education and service options.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.21(231C) Occupancy agreement.

69.21(1) The occupancy agreement shall be in 12-point type or larger, shall be written in plain language using commonly understood terms and shall be easy for the tenant or the tenant's legal representative to understand.

69.21(2) In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments:

- a. The telephone number for filing a complaint with the department.
- b. The telephone number for the office of long-term care ombudsman.
- c. The telephone number for reporting dependent adult abuse.
- d. A copy of the program's statement on tenants' rights.
- e. A statement that the tenant landlord law applies to assisted living programs.
- f. A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency.

69.21(3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.

69.21(4) A copy of the occupancy agreement shall be provided to the tenant or the tenant's legal representative, if any, and a copy shall be kept by the program.

69.21(5) A copy of the most current occupancy agreement shall be made available to the general public upon request. The basic marketing material shall include a statement that a copy of the occupancy agreement is available to all persons upon request.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.22(231C) Evaluation of tenant.

69.22(1) *Evaluation prior to occupancy.* A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.

69.22(2) *Evaluation within 30 days of occupancy.* A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change.

69.22(3) *Evaluation annually and with significant change.* A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.23(231C) Criteria for admission and retention of tenants.

69.23(1) *Persons who may not be admitted or retained.* A program shall not knowingly admit or retain a tenant who:

- a. Is bed-bound; or
- b. Requires routine, two-person assistance with standing, transfer or evacuation; or
- c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:

- (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression; or
- (2) Displays behavior that places another tenant at risk; or
 - d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or
 - e. Is under the age of 18; or
 - f. Requires more than part-time or intermittent health-related care; or
 - g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or
 - h. Is medically unstable; or
 - i. Requires maximal assistance with activities of daily living; or
 - j. Despite intervention, chronically urinates or defecates in places that are not considered acceptable according to societal norms, such as on the floor or in a potted plant.

69.23(2) *Disclosure of additional occupancy and transfer criteria.* A program may have additional occupancy or transfer criteria if the criteria are disclosed in the written occupancy agreement prior to the tenant's occupancy.

69.23(3) *Assistance with transfer from the program.* A program shall provide assistance to a tenant and the tenant's legal representative, if applicable, to ensure a safe and orderly transfer from the program when the tenant exceeds the program's criteria for admission and retention.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.24(231C) Involuntary transfer from the program.

69.24(1) *Program initiation of transfer.* If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:

a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the office of long-term care ombudsman.

b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any.

c. Pursuant to statute, the office of long-term care ombudsman shall offer the notified tenant or tenant's legal representative assistance with the program's internal appeal process. The tenant or tenant's legal representative is not required to accept the assistance of the office of long-term care ombudsman.

d. If, following the internal appeal process, the program upholds the transfer decision, the tenant or tenant's legal representative may utilize other remedies authorized by law to contest the transfer.

69.24(2) *Transfer pursuant to results of monitoring or complaint or program-reported incident investigation by the department.* If one or more tenants are identified as exceeding the admission and retention criteria for tenants and need to be transferred as a result of a monitoring or a complaint or program-reported incident investigation conducted by the department, the following procedures shall apply:

a. *Program agreement with the department's finding.* If the program agrees with the department's finding and the program begins involuntary transfer proceedings, the program's internal appeal process in subrule 69.24(1) shall be utilized for appeals.

b. *Program disagreement with the department's finding.* If the program does not agree with the department's finding that the tenant exceeds admission and retention criteria, the program may appeal the department's final report as provided in rule 481—67.14(17A,231B,231C,231D,85GA,HF2365). If an appeal is filed, the tenant who exceeds admission and retention criteria shall be allowed to continue living at the program until all administrative appeals have been exhausted. Appeals filed that relate to the tenant's exceeding admission and retention criteria shall be heard within 30 days of receipt, and appropriate services to meet the tenant's needs shall be provided during that period of time.

c. Request for waiver of criteria for retention of a tenant in a program. To allow a tenant to remain in the program, the program may request a waiver of criteria for retention of a tenant pursuant to rule 481—67.7(231B,231C,231D) from the department within 10 working days of the receipt of the report. [ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.25(231C) Tenant documents.

69.25(1) Documentation for each tenant shall be maintained by the program and shall include:

- a.* An occupancy record including the tenant's name, birth date, and home address; identification numbers; date of occupancy; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;
- b.* Application forms;
- c.* The initial evaluations and updates;
- d.* A nutritional assessment as necessary;
- e.* The initial individual service plan and updates;
- f.* Signed authorizations for permission to release medical information, photographs, or other media information as necessary;
- g.* A signed authorization for the tenant to receive emergency medical care as necessary;
- h.* A signed managed risk policy and signed managed risk consensus agreements, if any;
- i.* When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;
- j.* Medication lists, which shall be maintained in conformance with 481—paragraph 67.5(2) "d";
- k.* Advance health care directives as applicable;
- l.* A complete copy of the tenant's occupancy agreement, including any updates;
- m.* A written acknowledgment that the tenant or the tenant's legal representative, if applicable, has been fully informed of the tenant's rights;
- n.* A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;
- o.* Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record);
- p.* A copy of waivers of admission or retention criteria, if any;
- q.* When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs); and
- r.* Authorizations for the release of information, if any.

69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant.

69.25(3) All records shall be protected from loss, damage and unauthorized use.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.26(231C) Service plans.

69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.

69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually.

a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.

b. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.

c. If a significant change relates to a recurring or chronic condition, a previous evaluation and service plan of the recurring condition may be utilized without new signatures being obtained. For example, with chronic exacerbation of a urinary tract infection, nurse review is adequate to institute the previously written evaluation and service plan.

d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties.

e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually.

69.26(4) The service plan shall be individualized and shall indicate, at a minimum:

a. The tenant's identified needs and preferences for assistance;

b. Any services and care to be provided pursuant to the occupancy agreement;

c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy;

d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests; and

e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.27(231C) Nurse review.

69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse:

a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and

b. To ensure that health care professionals' orders are current for tenants who receive health care professional-directed care from the program; and

c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; and

d. To provide the program with written documentation of the nurse review, showing the time, date and signature.

69.27(2) A licensed practical nurse via nurse delegation may complete the tasks required by this rule, except when a tenant experiences a significant change in condition.

NOTE: Refer to Table A at the end of this chapter. If the program does not provide personal or health-related care to a tenant, nurse review is not required.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.28(231C) Food service.

69.28(1) The program shall provide or coordinate with other community providers to provide a hot or other appropriate meal(s) at least once a day or shall make arrangements for the availability of meals.

69.28(2) Meals and snacks provided by the program but not prepared on site shall be obtained from or provided by an entity that meets the standards of state and local health laws and ordinances concerning the preparation and serving of food.

69.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program:

- a.* A minimum of 33½ percent if the program provides one meal per day;
- b.* A minimum of 66⅔ percent if the program provides two meals per day; and
- c.* One hundred percent if the program provides three meals per day.

69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets.

69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.

a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by:

- (1) Obtaining certification as a dietary manager; or
- (2) Obtaining certification as a food protection professional; or
- (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling.

b. If the person is in the process of completing a course or certification listed in paragraph "a," the requirement relating to completion of a state-approved food protection program shall be considered to have been met.

69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following:

a. All main meals and planned menu items must be prepared offsite and transferred to the program kitchen for service to tenants.

b. Baked goods that do not require temperature control for safety and single-service juice or milk may be stored in the program's kitchen and provided as part of a continental breakfast.

c. Ingredients used for food-related activities with tenants may be stored in the program's kitchen. Tenant activities may include the preparation and cooking of food items in the program's kitchen if the activity occurs on an irregular or sporadic basis and the items prepared are not part of the program's menu.

d. Appropriately trained staff may prepare in the program's kitchen individual quantities of tenant-requested menu-substitution food items that require limited or no preparation, such as peanut butter or cheese sandwiches or a single-service can of soup. The food items necessary to prepare the menu substitution may be stored in the program's kitchen. These food items may not be cooked in the program's kitchen but may be reheated in a microwave. A two- or four-slice toaster may be used for tenant-requested menu-substitution items, but no bare-hand contact is permitted.

e. Tenants may take food items left over from a meal back to their apartments. The program may not store leftovers in the program's kitchen.

f. Warewashing may be done in the program's kitchen as long as the program utilizes a commercial dishwasher and documents daily testing of sanitizer chemical ppm and proper water temperatures. Verification by the department of these practices may be conducted during on-site visits.

69.28(7) Programs may have an on-site dietitian. Programs may secure menus and a dietitian through other methods.

69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 1376C, IAB 3/19/14, effective 4/23/14; ARC 2463C, IAB 3/16/16, effective 4/20/16; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.29(231C) Staffing. In addition to the general staffing requirements in rule 481—67.9(231B,231C,231D), the following requirements apply to staffing in programs.

69.29(1) Each tenant shall have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch.

69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia shall follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s).

69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.

69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans.

A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans.

69.29(5) All programs employing a new program manager after January 1, 2010, shall require the manager within six months of hire to complete an assisted living management class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living programs. Managers who have completed a similar training prior to January 1, 2010, shall not be required to complete additional training to meet this requirement.

69.29(6) All programs employing a new delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule.

69.29(7) The program shall notify the department in writing within ten business days of a change in the program's manager.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.30(231C) Dementia-specific education for program personnel.

69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.

69.30(2) The dementia-specific education or training shall include, at a minimum, the following:

- a. An explanation of Alzheimer's disease and related disorders;
- b. The program's specialized dementia care philosophy and program;
- c. Skills for communicating with persons with dementia;

- d.* Skills for communicating with family and friends of persons with dementia;
- e.* An explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the care-giving role, and family dynamics;
- f.* The importance of planned and spontaneous activities;
- g.* Skills in providing assistance with instrumental activities of daily living;
- h.* The importance of the service plan and social history information;
- i.* Skills in working with challenging tenants;
- j.* Techniques for simplifying, cueing, and redirecting;
- k.* Staff support and stress reduction; and
- l.* Medication management and nonpharmacological interventions.

69.30(3) Dementia-specific continuing education.

a. Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually.

b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually.

c. Contracted personnel who have no contact with tenants (e.g., persons providing lawn maintenance or snow removal) are not required to receive the two hours of training required in paragraph “a.”

d. The contracting agency may provide the program with documentation of dementia-specific continuing education that meets the requirements of this subrule.

69.30(4) An employee or contractor who provides documentation of completion of a dementia-specific education or training program within the past 12 months shall be exempt from the education and training requirement of subrule 69.30(1).

69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.31(231C) Managed risk policy and managed risk consensus agreements. The program shall have a managed risk policy. The managed risk policy shall be provided to the tenant along with the occupancy agreement. The managed risk policy shall include the following:

69.31(1) An acknowledgment of the shared responsibility for identifying and meeting the needs of the tenant and the process for managing risk and for upholding tenant autonomy when tenant decision making could result in poor outcomes for the tenant or others; and

69.31(2) A consensus-based process to address specific risk situations. Program staff and the tenant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the tenant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the tenant’s file.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—69.32(231C) Life safety—emergency policies and procedures and structural safety requirements.

69.32(1) The program shall submit to the department and follow written emergency policies and procedures, which shall include the following:

- a.* An emergency plan, which shall include procedures for natural disasters (identify where the plan is located for easy reference);
- b.* Fire safety procedures;
- c.* Other general or personal emergency procedures;
- d.* Provisions for amending or revising the emergency plan;
- e.* Provisions for periodic training of all employees;
- f.* Procedures for fire drills;

- g.* Regulations regarding smoking;
- h.* Monitoring and testing of smoke-control systems;
- i.* Tenant evacuation procedures; and
- j.* Procedures for reporting and documentation.

69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

69.32(3) The program shall obtain approval from the state fire marshal division of the department of public safety before the installation of any delayed-egress specialized locking systems.

69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have:

- a.* Written procedures regarding alarm systems, if an alarm system is in place.
- b.* Written procedures regarding appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior.
- c.* Written procedures regarding appropriate staff response if a tenant with cognitive disorder or dementia is missing.

69.32(5) The program's structure and procedures and the facility in which a program is located shall meet the requirements adopted for assisted living programs in administrative rules promulgated by the state fire marshal. Approval of the state fire marshal indicating that the building is in compliance with these requirements is necessary for certification of a program.

69.32(6) The program shall have the means to control the maximum temperature of water at sources accessible by a tenant to prevent scalding and shall control the maximum water temperature for tenants with cognitive impairment or dementia or at a tenant's request.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.33(231C) Transportation. When transportation services are provided directly or under contract with the program:

69.33(1) The vehicle shall be accessible and appropriate to the tenants who use it, with consideration for any physical disabilities and impairments.

69.33(2) Every tenant transported shall have a seat in the vehicle, except for a tenant who remains in a wheelchair during transport.

69.33(3) Vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers.

69.33(4) Wheelchairs shall be secured when the vehicle is in motion.

69.33(5) During loading and unloading of a tenant, the driver shall be in the proximate area of the tenants in a vehicle.

69.33(6) The driver shall have a valid and appropriate Iowa driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated.

69.33(7) Each vehicle shall have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.34(231C) Activities.

69.34(1) The program shall provide appropriate activities for each tenant. Activities shall reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement.

69.34(2) Activities shall be planned to support the tenant's service plan and shall be consistent with the program statement and occupancy policies.

69.34(3) A written schedule of activities shall be developed at least monthly and made available to tenants and their legal representatives.

69.34(4) Tenants shall be given the opportunity to choose their levels of participation in all activities offered in the program.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.35(231C) Structural requirements.

69.35(1) General requirements.

- a. The structure of the program shall be designed and operated to meet the needs of the tenants.
- b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.
- c. Programs shall have private dwelling units with a single-action, lockable entrance door.
- d. A program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, shall have the means to disable or remove the lock on an entrance door and shall disable or remove the lock if its presence presents a danger to the health and safety of the tenant.
- e. The structure in which a program is housed shall comply with the administrative rules promulgated by the state fire marshal.
- f. Programs may have individual cooking facilities within the private dwelling units. Any program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, shall have the means to disable or easily remove appliances and shall disable or remove them if their presence presents a danger to the health and safety of the tenant or others.

69.35(2) Programs certified prior to July 4, 2001. Facilities for programs certified prior to July 4, 2001, shall meet the following requirements:

- a. Each dwelling unit shall have at least one room that shall have not less than 120 square feet of floor area. Other habitable rooms shall have an area of not less than 70 square feet.
- b. Each dwelling unit shall have not less than 190 square feet of floor area, excluding bathrooms.
- c. A dwelling unit used for double occupancy shall have not less than 290 square feet of floor area, excluding bathrooms.
- d. The program shall have a minimum of 15 square feet of common area per tenant.

69.35(3) New construction built on or after July 4, 2001. Programs operated in new construction built on or after July 4, 2001, shall meet the following requirements:

- a. Each dwelling unit shall have at least one room that shall have not less than 120 square feet of floor area. Other habitable rooms shall have an area of not less than 70 square feet.
- b. Each dwelling unit used for single occupancy shall have a total square footage of not less than 240 square feet of floor area, excluding bathrooms and door swing.
- c. A dwelling unit used for double occupancy shall have a total square footage of not less than 340 square feet of floor area, excluding bathrooms and door swing.
- d. Each dwelling unit shall contain a bathroom, including but not limited to a toilet, sink and bathing facilities. A program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, shall have the means to disable or remove the sink or bathing facility water control and shall disable or remove the water control if its presence presents a danger to the health and safety of the tenant.

e. Self-closing doors are not required for individual dwelling units, whether in a general or dementia-specific setting, unless the authority with jurisdiction determines that the level of hazard has increased to require the installation of closure hardware (for example, presence of a stove, range or oven).

69.35(4) Structure being converted to or remodeled for use by a program on or after July 4, 2001. A program operating in a structure that was converted or remodeled for use for a program on or after July 4, 2001, shall meet the following requirements:

- a. Each dwelling unit shall have at least one room that has not less than 120 square feet of floor area. Other habitable rooms shall have an area of not less than 70 square feet.
- b. Each dwelling unit used for single occupancy shall have a total square footage of not less than 190 square feet of floor area, excluding bathrooms and door swing.
- c. A dwelling unit used for double occupancy shall have a total square footage of not less than 290 square feet of floor area, excluding bathrooms and door swing.

d. Each dwelling unit shall have a bathroom, including but not limited to a toilet, sink and bathing facility.

[ARC 8176B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—69.36(231C) Dwelling units in dementia-specific programs. Dementia-specific programs are exempt from the requirements in subrules 69.35(2) to 69.35(4) as follows:

69.36(1) For a program built in a family or neighborhood design:

a. Each dwelling unit used for single occupancy shall have a total square footage of not less than 150 square feet of floor area, excluding a bathroom; and

b. Each dwelling unit used for double occupancy shall have a total square footage of not less than 250 square feet of floor area, excluding a bathroom.

69.36(2) Dementia-specific programs may choose not to provide bathing facilities in the dwelling units.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.37(231C) Landlord and tenant Act. Iowa Code chapter 562A, the uniform residential landlord and tenant Act, shall apply to programs under this chapter.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.38(83GA,SF203) Identification of veteran’s benefit eligibility.

69.38(1) Within 30 days of a tenant’s admission to an assisted living program that receives reimbursement through the medical assistance program under Iowa Code chapter 249A, the program shall ask the tenant or the tenant’s personal representative whether the tenant is a veteran or whether the tenant is the spouse, widow, or dependent of a veteran and shall document the response.

69.38(2) If the program determines that the tenant may be a veteran or the spouse, widow, or dependent of a veteran, the program shall report the tenant’s name along with the name of the veteran, if applicable, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. When appropriate, the program may also report such information to the Iowa department of human services.

69.38(3) If a tenant is eligible for benefits through the U.S. Department of Veterans Affairs or other third-party payor, the program first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

[ARC 8176B, IAB 9/23/09, effective 1/1/10]

481—69.39(231C) Respite care services. “Respite care services” means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. “Respite care individual” means an individual receiving respite care services. An assisted living program which chooses to provide respite care services must meet the following requirements related to respite care services and must be certified as an assisted living program.

69.39(1) Length of stay. Respite care services shall be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period. The 12-month period begins on the first day of the respite care individual’s stay in the program.

69.39(2) No separate certificate. An assisted living program that chooses to provide respite care services is not required to obtain a separate certificate or pay a certification fee.

69.39(3) Assessment. The program nurse shall conduct an assessment of the respite care individual prior to the respite care individual’s stay. The assessment shall be documented and shall include, at a minimum:

- a.* Safety and supervision needs;
- b.* Medical needs;
- c.* Dietary needs; and
- d.* Bowel and bladder function.

69.39(4) *Written direction to staff.* The program nurse shall document the care needs of the respite care individual based on the assessment conducted pursuant to subrule 69.39(3) and provide the documentation to staff.

69.39(5) *Involuntary termination of respite care services.* The program may terminate the respite care services for a respite care individual. Rule 481—69.24(231C) shall not apply. The program shall make proper arrangements for the welfare of the respite care individual prior to involuntary termination of respite care services, including notification of the respite care individual's family or legal representative.

69.39(6) *Contract.* The program shall have a contract with each respite care individual. The contract shall, at a minimum, include the following:

a. The time period during which the individual will be considered to be receiving respite care services, not to exceed 30 consecutive days.

b. A description of all fees, charges, and rates for respite care services, and any additional and optional services and their related costs.

c. A statement that respite care services may be involuntarily terminated. Rule 481—69.24(231C) shall not apply.

d. Identification of the party responsible for payment of fees and identification of the respite care individual's legal representative, if any.

e. Identification of emergency contacts, including but not limited to the respite care individual's family member(s) and physician.

f. A statement that all respite care individual information shall be maintained in a confidential manner to the extent required under state and federal law.

g. The refund policy, if applicable.

h. A statement regarding billing and payment procedures.

69.39(7) *Admission to program.*

a. A respite care individual shall not be considered an admission to the program.

b. A respite care individual shall be included in the program's census.

c. The program shall not enter into multiple 30-day contracts with a respite care individual in order to lengthen the respite care individual's stay in the program.

d. If a respite care individual remains in the program beyond 30 consecutive days and is eligible for admission, the department shall consider the individual a tenant in the program. The program shall follow all requirements for admission to the program.

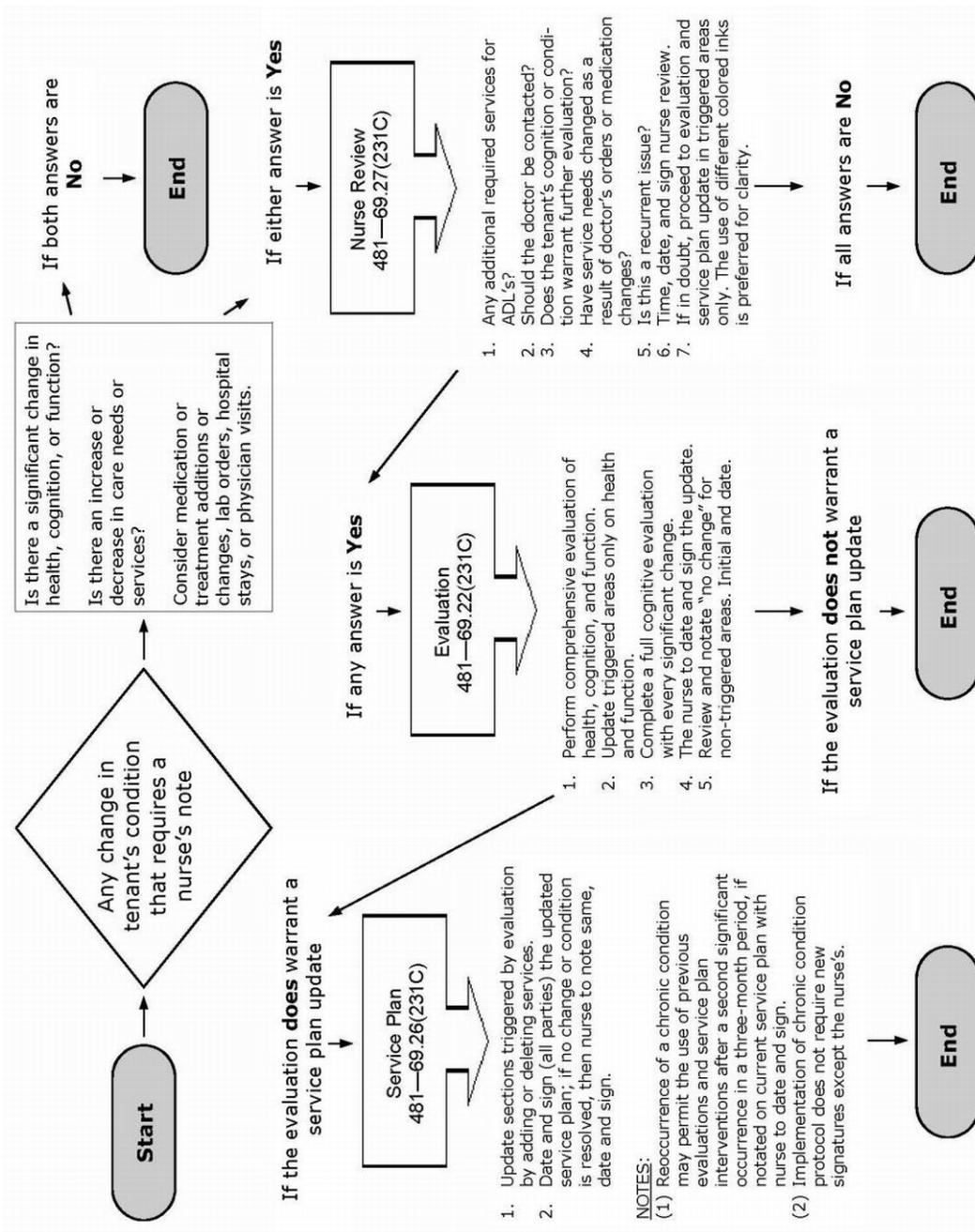
69.39(8) *Level of care criteria.* Respite care individuals must meet the criteria found in subrule 69.23(1) for admission and retention of tenants. Respite care services shall not be provided by an assisted living program to persons requiring a level of care which is higher than the level of care the program is certified to provide.

69.39(9) *Accessibility by the department.* The department shall have the same access to respite care services records as provided in 481—subrule 67.10(2).

[ARC 1667C, IAB 10/15/14, effective 11/19/14]

These rules are intended to implement Iowa Code chapter 231C.

Table A



[Filed ARC 8176B (Notice ARC 7878B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]
 [Filed ARC 1376C (Notice ARC 1291C, IAB 1/22/14), IAB 3/19/14, effective 4/23/14]
 [Filed ARC 1667C (Notice ARC 1511C, IAB 6/25/14), IAB 10/15/14, effective 11/19/14]
 [Filed ARC 1927C (Notice ARC 1860C, IAB 2/4/15), IAB 4/1/15, effective 5/6/15]
 [Filed ARC 2463C (Notice ARC 2200C, IAB 10/14/15), IAB 3/16/16, effective 4/20/16]
 [Filed ARC 4976C (Notice ARC 4867C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

CHAPTER 70
ADULT DAY SERVICES

481—70.1(231D) Definitions. In addition to the definitions in 481—Chapter 67 and Iowa Code chapter 231D, the following definitions apply.

“*Accredited*” means that the program has received accreditation from an accreditation entity recognized in subrule 70.14(1).

“*Adult day services*” or “*adult day services program*” or “*program*” means an organized program providing a variety of health-related care, social services, and other related support services for 16 hours or less in a 24-hour period to two or more persons with a functional impairment on a regularly scheduled, contractual basis.

“*Applicable requirements*” means Iowa Code chapter 231D, this chapter, and 481—Chapter 67 and includes any other applicable administrative rules and provisions of the Iowa Code.

“*CARF*” means the Commission on Accreditation of Rehabilitation Facilities.

“*Change of ownership*” means the purchase, transfer, assignment or lease of a certified adult day services program and includes a change in the management company responsible for the day-to-day operation of the program, if the management company is ultimately responsible for any enforcement action taken by the department.

“*Cognitive disorder*” means a disorder characterized by cognitive dysfunction presumed to be the result of illness that does not meet criteria for dementia, delirium, or amnesic disorder.

“*Contractual agreement*” means a written agreement between the program and the participant or legal representative.

“*Dementia-specific adult day services program*” means an adult day services program certified under this chapter that:

1. Serves fewer than 55 participants and has 5 or more participants who have dementia between Stages 4 and 7 on the Global Deterioration Scale, or
2. Serves 55 or more participants and 10 percent or more of the participants have dementia between Stages 4 and 7 on the Global Deterioration Scale, or
3. Holds itself out as providing specialized care for persons with dementia, such as Alzheimer’s disease, in a dedicated setting.

“*Functional impairment*” means a psychological, cognitive, or physical impairment that creates an inability to perform personal and instrumental activities of daily living and associated tasks and that necessitates some form of supervision or assistance or both.

“*Maximal assistance with activities of daily living*” means routine total dependence on staff for the performance of a minimum of four activities of daily living for a period that exceeds 21 days.

“*Medically unstable*” means that a participant has a condition or conditions:

1. Indicating physiological frailty as determined by the program’s staff in consultation with a physician or physician extender;
2. Resulting in three or more significant hospitalizations within a consecutive three-month period for more than observation; and
3. Requiring frequent supervision of the participant for more than 21 days by a registered nurse.

For example, a participant who has a condition such as congestive heart failure which results in three or more significant hospitalizations during a quarter and which requires that the participant receive frequent supervision may be considered medically unstable.

“*Nonaccredited*” means that the program has been certified under the provisions of this chapter but has not received accreditation from the accreditation entity recognized in subrule 70.14(1).

“*Participant*” means an individual who is the recipient of services provided by an adult day services program.

“*Participant’s legal representative*” means a person appointed by the court to act on behalf of a participant, or a person acting pursuant to a power of attorney.

“*Unmanageable incontinence*” means a condition that requires staff provision of total care for an incontinent participant who lacks the ability to assist in bladder or bowel continence care.

“*Unmanageable verbal abuse*” means repeated verbalizations against participants or staff that persist despite all interventions and negatively affect the program. “Unmanageable verbal abuse” includes but is not limited to threats, frequent use of profane language, or unwelcome sexually oriented remarks.

“*Visiting day(s)*” means up to 16 hours in a two-day period during which a person may visit a program prior to admission for the purpose of assessing eligibility for the program and personal satisfaction.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—70.2(231D) Program certification. A program may obtain certification by meeting all applicable requirements. In addition, a program may be voluntarily accredited by a recognized accreditation entity. For the purpose of these rules, certification is equivalent to licensure.

70.2(1) Posting requirements. A program’s current certificate shall be visibly displayed within the designated operation area of the program. In addition, the latest monitoring report, state fire marshal report, and food establishment inspections report issued pursuant to Iowa Code chapter 137F shall be made available to the public by the program upon request.

70.2(2) Dementia-specific programs and door alarms. If a program meets the definition of a dementia-specific adult day services program during two sequential certification monitorings, the program shall meet all requirements for a dementia-specific program, including the requirements set forth in rule 481—70.30(231D) and in subrule 70.32(2), which includes the requirements relating to door alarms.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.3(231D) Certification of a nonaccredited program—application process.

70.3(1) The applicant shall complete an application packet obtained from the department. Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do; by mail from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.

70.3(2) The applicant shall submit one copy of the completed application and all supporting documentation to the department at the above address at least 90 calendar days prior to the expected date of beginning operation.

70.3(3) The appropriate fee as stated in Iowa Code section 231D.4 shall accompany each application and be payable by check or money order to the Department of Inspections and Appeals. Fees are nonrefundable.

70.3(4) The department shall consider the application when all supporting documents and fees are received.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.4(231D) Nonaccredited program—application content. An application for certification or recertification of a nonaccredited program shall include the following:

70.4(1) A list that includes the names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

- a. The real estate owner or lessor;
- b. The lessee; and
- c. The management company responsible for the day-to-day operation of the program.

The program shall notify the department of any changes in the list no later than ten working days after the effective date of the change.

70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined in Iowa Code section 135C.1, or licensed hospital as defined in Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.

70.4(4) The policy and procedure for evaluation of each participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each participant shall be included.

70.4(5) The policy and procedure for service plans.

70.4(6) The policy and procedure for addressing medication needs of participants.

70.4(7) The policy and procedure for accidents and emergency response.

70.4(8) The policies and procedures for food service, including those relating to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.

70.4(9) The policy and procedure for activities.

70.4(10) The policy and procedure for transportation.

70.4(11) The policy and procedure for staffing and training.

70.4(12) The policy and procedure for emergencies, including natural disasters. The policy and procedure shall include an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.

70.4(13) The policy and procedure for managing risk and upholding participant autonomy when participant decision making results in poor outcomes for the participant or others.

70.4(14) The policy and procedure for reporting incidents including dependent adult abuse as required in rule 481—67.2(231B,231C,231D).

70.4(15) The policy and procedure related to life safety requirements for a dementia-specific program as required by subrule 70.32(2).

70.4(16) The participant contractual agreement and all attachments.

70.4(17) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

70.4(18) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

70.4(19) The fee set forth in Iowa Code section 231D.4.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—70.5(231D) Initial certification process for a nonaccredited program.

70.5(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation review approval, the department shall determine whether the proposed program meets applicable requirements.

70.5(2) If, based upon the review of the complete application, including all required supporting documents, the department determines the proposed program meets the requirements for certification, a provisional certification shall be issued to the program to begin operation and accept participants.

70.5(3) Within 180 calendar days following issuance of provisional certification, the department shall conduct a monitoring to determine the program's compliance with applicable requirements.

70.5(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.

70.5(5) The department shall make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

70.5(6) The department shall notify the program of a final certification decision within 10 working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

70.5(7) If the decision is to continue certification, the department shall issue a full two-year certification effective from the date of the original provisional certification.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.6(231D) Expiration of the certification of a nonaccredited program.

70.6(1) Unless conditionally issued, suspended or revoked, certification of a program shall expire at the end of the time period specified on the certificate.

70.6(2) The department shall send recertification application materials to each program at least 120 calendar days prior to expiration of the program's certification.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.7(231D) Recertification process for a nonaccredited program. To obtain recertification, a program shall:

70.7(1) Submit one copy of the completed application, including the information required in rule 481—70.4(231D), associated documentation, and the recertification fee as listed in Iowa Code section 231D.4 to the department at the address stated in subrule 70.3(1) at least 90 calendar days prior to the expiration of the program's certification. The program need not submit policies and procedures that have been previously submitted to the department and remain unchanged. The program shall provide a list of the policies and procedures that have been previously submitted and are not being resubmitted.

70.7(2) Submit additional documentation that each of the following has been inspected by a qualified professional and found to be maintained in conformance with the manufacturer's recommendations and nationally recognized standards: heating system, cooling system, water heater, electrical system, plumbing, sewage system, artificial lighting, and ventilation system; and, if located on site, garbage disposal, kitchen appliances, washing machines and dryers, and elevators.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.8(231D) Notification of recertification for a nonaccredited program.

70.8(1) The department shall review the application and associated documentation and fees. If the application is incomplete, the department shall contact the program to request the additional information. After all finalized documentation is received, including state fire marshal approval, the department shall determine the program's compliance with applicable requirements.

70.8(2) The department shall conduct a monitoring of the program between 60 and 90 days prior to expiration of the program's certification.

70.8(3) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) shall be followed.

70.8(4) If no regulatory insufficiency is identified as a result of the monitoring, the department shall issue a report of the findings with the final recertification decision.

70.8(5) If the decision is to recertify, the department shall issue the program a two-year certification effective from the date of the expiration of the previous certification.

70.8(6) If the decision is to deny recertification, the department shall issue a notice of denial and provide the program the opportunity for a hearing pursuant to rule 481—67.13(17A,231B,231C,231D).

70.8(7) If the department is unable to recertify a program through no fault of the program, the department shall issue to the program a time-limited extension of certification of no longer than one year.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.9(231D) Certification or recertification of an accredited program—application process.

70.9(1) An applicant for certification or recertification of a program accredited by a recognized accrediting entity shall:

a. Submit a completed application packet obtained from the department. Application materials may be obtained from the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do; by mail from the Department of Inspections and

Appeals, Adult Services Bureau, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; or by telephone at (515)281-6325.

b. Submit a copy of the current accreditation outcome from the recognized accrediting entity.

c. Apply for certification or recertification within 90 calendar days following verification of compliance with the requirements of the state fire marshal division of the department of public safety pursuant to this chapter.

d. Submit the appropriate fees as set forth in Iowa Code section 231D.4.

70.9(2) The department shall not consider an application until it is complete and includes all supporting documentation and the appropriate fees.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—70.10(231D) Certification or recertification of an accredited program—application content. An application for certification or recertification of an accredited program shall include the following:

70.10(1) A list that includes the names, addresses and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors, and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

a. The real estate owner or lessor;

b. The lessee; and

c. The management company responsible for the day-to-day operation of the program.

The program shall notify the department of any changes in the list no later than ten working days after the effective date of the change.

70.10(2) A statement disclosing whether the individuals listed in subrule 70.10(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

70.10(3) A statement disclosing whether any of the individuals listed in subrule 70.10(1) have or have had an ownership interest in an adult day services program, assisted living program, elder group home, home health agency, licensed health care facility as defined under Iowa Code section 135C.1, or licensed hospital as defined under Iowa Code section 135B.1, which has been closed in any state due to removal of program, agency, or facility licensure or certification or due to involuntary termination from participation in either the Medicaid or Medicare program; or have been found to have failed to provide adequate protection or services to prevent abuse or neglect of residents, patients, tenants or participants.

70.10(4) A copy of the current accreditation outcome from the recognized accrediting entity.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—70.11(231D) Initial certification process for an accredited program.

70.11(1) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine and notify the accredited program whether the accredited program meets applicable requirements and whether certification will be issued.

70.11(2) If the decision is to certify, a certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

70.11(3) If the decision is to deny certification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

70.11(4) Unless conditionally issued, suspended or revoked, certification for a program shall expire at the end of the time period specified on the certificate.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.12(231D) Recertification process for an accredited program.

70.12(1) The department shall send recertification application materials to each program at least 120 calendar days prior to expiration of the program's certification.

70.12(2) To obtain recertification, an accredited program shall submit one copy of the completed application, associated documentation, and the administrative fee as stated in Iowa Code section 231D.4 to the department at the address stated in subrule 70.9(1) at least 90 calendar days prior to the expiration of the program's certification.

70.12(3) Within 20 working days of receiving all finalized documentation, including state fire marshal approval, the department shall determine the program's compliance with applicable requirements and make a recertification decision.

70.12(4) The department shall notify the accredited program within 10 working days of the final recertification decision.

a. If the decision is to recertify, a full certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

b. If the decision is to deny recertification, the department shall provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

70.12(5) If the department is unable to recertify a program through no fault of the program, the department shall issue to the program a time-limited extension of certification of no longer than one year.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.13(231D) Listing of all certified programs. The department shall maintain a list of all certified programs, which is available online at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Entities Book" tab.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.14(231D) Recognized accrediting entity.

70.14(1) The department designates CARF as a recognized accrediting entity for programs.

70.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request, and its standards shall, at minimum, meet the applicable requirements for programs.

70.14(3) The designation shall remain in effect for as long as the accreditation standards continue to meet, at minimum, the applicable requirements for programs.

70.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.15(231D) Requirements for an accredited program. Each accredited program that is certified by the department shall:

70.15(1) Provide the department a copy of all survey reports including outcomes, quality improvement plans and annual conformance to quality reports generated or received, as applicable, within ten working days of receipt of the reports.

70.15(2) Notify the department by the most expeditious means possible of all credible reports of alleged improper or inappropriate conduct or conditions within the program and any actions taken by the accrediting entity with respect thereto.

70.15(3) Notify the department immediately of the expiration, suspension, revocation or other loss of the program's accreditation.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.16(231D) Maintenance of program accreditation.

70.16(1) An accredited program shall continue to be recognized for certification by the department if both of the following requirements are met:

a. The program complies with the requirements outlined in rule 481—70.15(231D).

b. The program maintains its voluntary accreditation status for the duration of the time-limited certification period.

70.16(2) A program that does not maintain its voluntary accreditation status must become certified by the department prior to any lapse in accreditation.

70.16(3) A program that does not maintain its voluntary accreditation status and is not certified by the department prior to any lapse in voluntary accreditation shall cease operation as a program.
[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.17(231D) Change of ownership—notification to the department.

70.17(1) Certification, unless conditionally issued, suspended or revoked, may be transferable. If the program's certification has been conditionally issued, the department must approve a change of ownership prior to the transfer of the certification.

70.17(2) In order to transfer certification, the applicant must:

a. Meet the requirements of the rules, regulations and standards contained in Iowa Code chapter 231D and 481—Chapter 67 and this chapter; and

b. At least 30 days prior to the change of ownership of the program, make application on forms provided by the department.

70.17(3) The department may conduct a monitoring within 90 days following a change in the program's ownership to ensure that the program complies with applicable requirements. If a regulatory insufficiency is found, the department shall take any necessary enforcement action authorized by applicable requirements.

[ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—70.18(231D) Plan reviews of a building for a new program.

70.18(1) Before a building is constructed or remodeled for use in a new program, the state fire marshal division of the department of public safety shall review the blueprints for compliance with requirements pursuant to this chapter. Construction or remodeling includes new construction, remodeling of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building.

70.18(2) A program applicant shall submit blueprints wet-sealed by an Iowa-licensed architect or Iowa-licensed engineer and the blueprint plan review fee as stated in Iowa Code section 231D.4 to the Department of Public Safety, State Fire Marshal Division, 215 E. 7th Street, Third Floor, Des Moines, Iowa 50319.

70.18(3) Failure to submit the blueprint plan review fee with the blueprints shall result in delay of the blueprint plan review until the fee is received.

70.18(4) The state fire marshal division of the department of public safety shall review the blueprints and notify the Iowa-licensed architect or Iowa-licensed engineer in writing regarding the status of compliance with requirements.

70.18(5) The Iowa-licensed architect or Iowa-licensed engineer shall respond to the state fire marshal division of the department of public safety to state how any noncompliance will be resolved.

70.18(6) Upon final notification by the state fire marshal division of the department of public safety that the blueprints meet structural and life safety requirements, construction or remodeling of the building may commence.

70.18(7) The state fire marshal division of the department of public safety shall schedule an on-site visit of the building site with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the construction or remodeling process to ensure compliance with the approved blueprints. Any noncompliance must be resolved prior to approval for certification.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—70.19(231D) Plan review prior to the remodeling of a building for a certified program.

70.19(1) Before a building for a certified program is remodeled, the state fire marshal division of the department of public safety shall review the blueprints for compliance with requirements set forth in

rule 481—70.35(231D). Remodeling includes modification of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building.

70.19(2) A certified program shall submit blueprints wet-sealed by an Iowa-licensed architect or Iowa-licensed engineer and the blueprint plan review fee as stated in Iowa Code section 231D.4 to the Department of Public Safety, State Fire Marshal Division, 215 E. 7th Street, Third Floor, Des Moines, Iowa 50319.

70.19(3) Failure to submit the blueprint plan review fee with the blueprints shall result in delay of the blueprint plan review until the fee is received.

70.19(4) The state fire marshal division of the department of public safety shall review the blueprints within 20 working days of receipt and immediately notify the Iowa-licensed architect or Iowa-licensed engineer in writing regarding the status of compliance with requirements.

70.19(5) The Iowa-licensed architect or Iowa-licensed engineer shall respond to the state fire marshal division of the department of public safety in 20 working days to state how any noncompliance will be resolved.

70.19(6) Upon final notification by the state fire marshal division of the department of public safety that the blueprints meet structural and life safety requirements, remodeling of the building may commence.

70.19(7) The state fire marshal division of the department of public safety shall schedule an on-site visit of the building with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the remodeling process to ensure compliance with the approved blueprints. Any noncompliance must be resolved prior to approval for continued certification or recertification of the program.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—70.20(231D) Cessation of program operation.

70.20(1) If a certified program ceases operation, which includes seeking decertification, at any time prior to expiration of the program's certification, the program shall submit the certificate to the department. The program shall provide, at least 90 days in advance of cessation, which includes seeking decertification, unless there is some type of emergency, written notification to the department of the date on which the program will cease operation, which includes seeking decertification.

70.20(2) If a certified program plans to cease operation, which includes seeking decertification, at the time the program's certification expires, the program shall provide written notice of this fact to the department at least 90 days prior to expiration of the certification.

70.20(3) At the time a program decides to cease operation, which includes seeking decertification, the program shall submit a plan to the department and make arrangements for the safe and orderly discharge or transition of all participants within the 90-day period specified by subrule 70.20(2).

70.20(4) The department may conduct a monitoring during the 90-day period to ensure the safety of participants during the discharge process or transition process.

70.20(5) The department may conduct an on-site visit to verify that the program has ceased operation as a certified program in accordance with the notice provided by the program.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.21(231D) Contractual agreement.

70.21(1) The contractual agreement shall be in 12-point type or larger, shall be written in plain language using commonly understood terms and shall be easy for the participant or the participant's legal representative to understand.

70.21(2) In addition to the requirements of Iowa Code section 231D.17, the written contractual agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments:

- a. The telephone number for filing a complaint with the department.
- b. The telephone number for reporting dependent adult abuse.
- c. A copy of the program's statement on participants' rights.
- d. A statement that the program will notify the participant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency.

e. A copy of the program's admission and discharge criteria.

70.21(3) The contractual agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.

70.21(4) A copy of the contractual agreement shall be provided to the participant or the participant's legal representative, if any, and a copy shall be kept by the program.

70.21(5) A copy of the most current contractual agreement shall be made available to the general public upon request. The basic marketing material shall include a statement that a copy of the contractual agreement is available to all persons upon request.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.22(231D) Evaluation of participant.

70.22(1) *Evaluation prior to participation.* A program shall evaluate each prospective participant's functional, cognitive and health status prior to the participant's signing the contractual agreement and participating in the program, with the exception of visiting day(s), to determine the participant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall be appropriate to the population served. When the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the participant subsequently returns to the participant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional.

70.22(2) *Evaluation within 30 days of participation and with significant change.* A program shall evaluate each participant's functional, cognitive and health status within 30 days of the participant's beginning participation in the program. A program shall also evaluate each participant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the participant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the participant has not exhibited a significant change.

70.22(3) *Requirements for visiting day(s).* Evaluation of the participant is not required during visiting day(s), but the program shall provide the participant or the participant's legal representative with a written explanation of the expectations for the visiting day(s).

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.23(231D) Criteria for admission and retention of participants.

70.23(1) *Persons who may not be admitted or retained.* A program shall not knowingly admit or retain a participant who:

- a.* Requires routine, three-person assistance with standing, transfer or evacuation; or
- b.* Is dangerous to self or other participants or staff, including but not limited to a participant who:
 - (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse; or
 - (2) Is in an acute stage of alcoholism, drug addiction, or mental illness; or
- c.* Is under the age of 18.

70.23(2) *Disclosure of additional participation and discharge criteria.* A program may have additional participation or discharge criteria if the criteria are disclosed in the written contractual agreement prior to the participant's participation in the program.

70.23(3) *Assistance with discharge from the program.* A program shall provide assistance to a participant and the participant's legal representative, if applicable, to ensure a safe and orderly discharge from the program when the participant exceeds the program's criteria for admission and retention.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 1547C, IAB 7/23/14, effective 8/27/14]

481—70.24(231D) Involuntary discharge from the program.

70.24(1) *Program initiation of discharge.* If a program initiates the involuntary discharge of a participant and the action is not the result of a monitoring, including a complaint investigation or

program-reported incident investigation, by the department and if the participant or participant's legal representative contests the discharge, the following procedures shall apply:

a. The program shall notify the participant or participant's legal representative, in accordance with the contractual agreement, of the need to discharge the participant and of the reason for the discharge.

b. If, following the internal appeal process, the program upholds the discharge decision, the participant or participant's legal representative may utilize other remedies authorized by law to contest the discharge.

70.24(2) *Discharge pursuant to results of monitoring or complaint or program-reported incident investigation by the department.* If one or more participants are identified as exceeding the admission and retention criteria for participants and need to be discharged as a result of a monitoring or a complaint or program-reported incident investigation conducted by the department, the following procedures shall apply:

a. Notification of the program. Within 20 working days of the monitoring or complaint or program-reported incident investigation, the department shall notify the program, in writing, of the identification of any participant who exceeds admission and retention criteria.

b. Notification of others. Each identified participant, the participant's legal representative, if applicable, and other providers of services to the participant shall be notified of their opportunity to provide responses including: specific input, written comment, information, and documentation directly addressing any agreement or disagreement with the identification. All responses shall be provided to the department within 10 days of receipt of the notice.

c. Program agreement with the department's finding. If the program agrees with the department's finding and the program begins involuntary discharge proceedings, the program's internal appeal process in subrule 70.24(1) shall be utilized for appeals.

d. Program disagreement with the department's finding. If the program does not agree with the department's finding that the participant exceeds admission and retention criteria, the program may collect and submit all responses to the department, including those from other interested parties. In the program's response, the program shall identify the participant, list the known responses from others, and note the program's agreement or disagreement with the responses from others. The program's response shall be submitted to the department within 10 working days of the receipt of the notice. Submission of a response does not eliminate the applicable requirements, including submission of a plan of correction under 481—subrule 67.10(5). Other persons may also submit information directly to the department.

(1) Consideration of response. Within 10 working days of receipt of the program's response for each identified participant, the department shall consider the response and make a final finding regarding the continued retention of a participant.

(2) Amending the regulatory insufficiency. If the department's determination is to amend the regulatory insufficiency based on the response, the department shall modify the report of findings.

(3) Retaining regulatory insufficiency. If the department retains the regulatory insufficiency, the department shall review the plan of correction in accordance with this chapter and 481—Chapter 67. The department shall notify the program of the opportunity to appeal the report findings as they relate to the admission and retention decision.

(4) Effect of the filing of an appeal. If an appeal is filed, the participant who exceeds admission and retention criteria shall be allowed to continue to participate in the program until all administrative appeals have been exhausted. Appeals filed that relate to the participant's exceeding admission and retention criteria shall be heard within 30 days of receipt, and appropriate services to meet the participant's needs shall be provided during that period of time.

(5) Request for waiver of criteria for retention of a participant in a program. To allow a participant to continue to participate in the program, the program may request a waiver of criteria for retention of a participant pursuant to rule 481—67.7(231B,231C,231D) from the department within 10 working days of the receipt of the report.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.25(231D) Participant documents.

70.25(1) Documentation for each participant shall be maintained by the program and shall include:

- a. A participation record including the participant's name, birth date, and home address; identification numbers; date of beginning participation; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;

- b. Application forms;
- c. The initial evaluations and updates;
- d. A nutritional assessment as necessary;
- e. The initial individual service plan and updates;
- f. Signed authorizations for permission to release medical information, photographs, or other media information as necessary;

- g. A signed authorization for the participant to receive emergency medical care as necessary;
- h. A signed managed risk policy and signed managed risk consensus agreements, if any;
- i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;

- j. Medication lists, which shall be maintained in conformance with 481—paragraph 67.5(2)“d”;
- k. Advance health care directives as applicable;

- l. A complete copy of the participant's contractual agreement, including any updates;
- m. A written acknowledgment that the participant or the participant's legal representative, if applicable, has been fully informed of the participant's rights;

- n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;

- o. Incident reports involving the participant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the participant's medical record);

- p. A copy of waivers of admission or retention criteria, if any;
- q. When the participant is unable to advocate on the participant's own behalf or the participant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs); and

- r. Authorizations for the release of information, if any.

70.25(2) The program records relating to a participant shall be retained for a minimum of three years after the discharge or death of the participant.

70.25(3) All records shall be protected from loss, damage and unauthorized use.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 4976C, IAB 3/11/20, effective 4/15/20]

481—70.26(231D) Service plans.

70.26(1) A service plan shall be developed for each participant based on the evaluations conducted in accordance with subrules 70.22(1) and 70.22(2) and shall be designed to meet the specific service needs of the individual participant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

70.26(2) Prior to the participant's signing the contractual agreement and participating in the program, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the participant and, at the participant's request, with other individuals identified by the participant, and, if applicable, with the participant's legal representative. All persons who develop the plan and the participant or the participant's legal representative shall sign the plan.

70.26(3) When a participant needs personal care or health-related care, the service plan shall be updated within 30 days of the participant's participation and as needed with significant change, but not less than annually.

- a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties.

b. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.

c. If a significant change relates to a recurring or chronic condition, a previous evaluation and service plan of the recurring condition may be utilized without new signatures being obtained. For example, with chronic exacerbation of a urinary tract infection, nurse review is adequate to institute the previously written evaluation and service plan.

70.26(4) The service plan shall be individualized and shall indicate, at a minimum:

- a. The participant's identified needs and preferences for assistance;
 - b. Any services and care to be provided pursuant to the contractual agreement;
 - c. The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; and
 - d. For participants who are unable to plan their own activities, including participants with dementia, planned and spontaneous activities based on the participant's abilities and personal interests.
- [ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.27(231D) Nurse review. If a participant does not receive personal or health-related care, but an observed significant change in the participant's condition occurs, a nurse review shall be conducted. If a participant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

70.27(1) To monitor, at least every 90 days, or after a significant change in the participant's condition, any participant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders; and

70.27(2) To ensure that health care professionals' orders are current for participants who receive health care professional-directed care from the program; and

70.27(3) To assess and document the health status of each participant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the participant's health status; and

70.27(4) To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—70.26(231D), showing the time, date and signature.

NOTE: Refer to Table A at the end of this chapter. If the program does not provide personal or health-related care to a participant, nurse review is not required.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.28(231D) Food service.

70.28(1) The program shall provide or coordinate with other community providers to provide a hot or other appropriate meal(s) at least once a day or shall make arrangements for the availability of meals, unless otherwise noted in the contractual agreement.

70.28(2) Meals and snacks provided by the program but not prepared on site shall be obtained from or provided by an entity that meets the standards of state and local health laws and ordinances concerning the preparation and serving of food.

70.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program:

- a. A minimum of 33½ percent if the program provides one meal per day;
- b. A minimum of 66⅔ percent if the program provides two meals per day; and
- c. One hundred percent if the program provides three meals per day.

70.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced registered nurse practitioner. A current copy of the Iowa Simplified Diet Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be

responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets.

70.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.

a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by:

- (1) Obtaining certification as a dietary manager; or
- (2) Obtaining certification as a food protection professional; or
- (3) Successfully completing an ANSI-accredited certified food protection manager program

meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling.

b. If the person is in the process of completing a course or certification listed in paragraph "a," the requirement relating to completion of a state-approved food protection program shall be considered to have been met.

70.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following:

a. All main meals and planned menu items must be prepared offsite and transferred to the program kitchen for service to participants.

b. Baked goods that do not require temperature control for safety and single-service juice or milk may be stored in the program's kitchen and provided as part of a continental breakfast.

c. Ingredients used for food-related activities with participants may be stored in the program's kitchen. Participant activities may include the preparation and cooking of food items in the program's kitchen if the activity occurs on an irregular or sporadic basis and the items prepared are not part of the program's menu.

d. Appropriately trained staff may prepare in the program's kitchen individual quantities of participant-requested menu-substitution food items that require limited or no preparation, such as peanut butter or cheese sandwiches or a single-service can of soup. The food items necessary to prepare the menu substitution may be stored in the program's kitchen. These food items may not be cooked in the program's kitchen but may be reheated in a microwave. A two- or four-slice toaster may be used for participant-requested menu-substitution items, but no bare-hand contact is permitted.

e. Warewashing may be done in the program's kitchen as long as the program utilizes a commercial dishwasher and documents daily testing of sanitizer chemical ppm and proper water temperatures. Verification by the department of these practices may be conducted during on-site visits.

70.28(7) Programs may have an on-site dietitian. Programs may secure menus and a dietitian through other methods.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 1376C, IAB 3/19/14, effective 4/23/14; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—70.29(231D) Staffing. In addition to the general staffing requirements in rule 481—67.9(231B,231C,231D), the following requirements apply to staffing in programs.

70.29(1) No fewer than two staff persons who monitor participants shall be awake and on duty during all hours of operation when two or more participants are participating in the program.

70.29(2) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.

70.29(3) A program that serves one or more participants with cognitive disorders or dementia shall follow written procedures that address how the program will respond to the emergency needs of the participants.

70.29(4) The program shall notify the department in writing within ten business days of a change in the program's manager.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 1927C, IAB 4/1/15, effective 5/6/15]

481—70.30(231D) Dementia-specific education for program personnel.

70.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.

70.30(2) The dementia-specific education or training shall include, at a minimum, the following:

- a. An explanation of Alzheimer's disease and related disorders;
- b. The program's specialized dementia care philosophy and program;
- c. Skills for communicating with persons with dementia;
- d. Skills for communicating with family and friends of persons with dementia;
- e. An explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the care-giving role, and family dynamics;
- f. The importance of planned and spontaneous activities;
- g. Skills in providing assistance with instrumental activities of daily living;
- h. The importance of the service plan and social history information;
- i. Skills in working with challenging participants;
- j. Techniques for simplifying, cueing, and redirecting;
- k. Staff support and stress reduction; and
- l. Medication management and nonpharmacological interventions.

70.30(3) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually.

70.30(4) An employee or contractor who provides documentation of completion of a dementia-specific education or training program within the past 12 months shall be exempt from the education and training requirement of subrule 70.30(1).

70.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of participants in the program.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.31(231D) Managed risk policy and managed risk consensus agreements. The program shall have a managed risk policy. The managed risk policy shall be provided to the participant along with the contractual agreement. The managed risk policy shall include the following:

70.31(1) An acknowledgment of the shared responsibility for identifying and meeting the needs of the participant and the process for managing risk and for upholding participant autonomy when participant decision making results in poor outcomes for the participant or others; and

70.31(2) A consensus-based process to address specific risk situations. Program staff and the participant shall participate in the process. The result of the consensus-based process may be a managed risk consensus agreement. The managed risk consensus agreement shall include the signature of the participant and the signatures of all others who participated in the process. The managed risk consensus agreement shall be included in the participant's file.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.32(231D) Life safety—emergency policies and procedures and structural safety requirements.

70.32(1) The program shall submit to the department and follow written emergency policies and procedures, which shall include the following:

- a. An emergency plan, which shall include procedures for natural disasters (identify where the plan is located for easy reference);
- b. Fire safety procedures;
- c. Other general or personal emergency procedures;
- d. Provisions for amending or revising the emergency plan;
- e. Provisions for periodic training of all employees;
- f. Procedures for fire drills;
- g. Regulations regarding smoking;
- h. Monitoring and testing of smoke-control systems;
- i. Participant evacuation procedures; and
- j. Procedures for reporting and documentation.

70.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have:

- a. Written procedures regarding alarm systems and appropriate staff response when a participant's service plan indicates a risk of elopement or a participant exhibits wandering behavior.
- b. Written procedures regarding appropriate staff response if a participant with cognitive disorder or dementia is missing.
- c. The program shall obtain approval from the state fire marshal division before the installation of any delayed-egress specialized locking systems.

70.32(3) The program's structure and procedures and the facility in which a program is located shall meet the requirements adopted for adult day services programs in administrative rules promulgated by the state fire marshal. Approval of the state fire marshal indicating that the building is in compliance with these requirements is necessary for certification of a program.

70.32(4) The program shall have the means to control the maximum temperature of water at sources accessible by a participant to prevent scalding and shall control the maximum water temperature for participants with cognitive impairment or dementia or at a participant's request.

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—70.33(231D) Transportation. When transportation services are provided directly or under contract with the program:

70.33(1) The vehicle shall be accessible and appropriate to the participants who use it, with consideration for any physical disabilities and impairments.

70.33(2) Every participant transported shall have a seat in the vehicle, except for a participant who remains in a wheelchair during transport.

70.33(3) Vehicles shall have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers.

70.33(4) Wheelchairs shall be secured when the vehicle is in motion.

70.33(5) During loading and unloading of a participant, the driver shall be in the proximate area of the participants in a vehicle.

70.33(6) The driver shall have a valid and appropriate Iowa driver's license or commercial driver's license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated.

70.33(7) Each vehicle shall have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.34(231D) Activities.

70.34(1) The program shall provide appropriate activities for each participant. Activities shall reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement.

70.34(2) Activities shall be planned to support the participant's service plan and shall be consistent with the program statement and participation policies.

70.34(3) A written schedule of activities shall be developed at least monthly and made available to participants and their legal representatives.

70.34(4) Participants shall be given the opportunity to choose their levels of participation in all activities offered in the program.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

481—70.35(231D) Structural requirements.

70.35(1) The structure, equipment and physical environment of the program shall be designed and operated to meet the needs of the participants. The building, grounds and equipment shall be well-maintained, clean, safe and sanitary.

70.35(2) There shall be at least one toilet for every ten participants and staff members.

70.35(3) Toilets and bathing and toileting appliances shall be equipped for use by participants with multiple disabilities.

70.35(4) There shall be a ratio of at least one hand-washing sink for every two toilets. The sink(s) shall be proximate to the toilets. Hand-washing facilities shall be readily accessible to participants and staff.

70.35(5) Shower and tub areas, if provided, shall be equipped with grab bars and slip-resistant surfaces.

70.35(6) Signaling emergency call devices shall be installed or placed in all bathroom areas, restroom stalls and showers, if any.

70.35(7) A telephone shall be available to participants to make and receive calls in a private manner and for emergency purposes.

70.35(8) A storage area(s) shall be provided for storage of program supplies and participants' possessions, which shall be stored in such a manner that, when not in use, will prevent personal injury to participants and staff.

70.35(9) The program shall provide a separate area to permit privacy for evaluations and to isolate participants who become ill.

70.35(10) The program shall meet other building and public safety codes, including rules pertaining to accessibility contained in the state building code in 661—Chapter 302 and provisions of the state building code relating to persons with disabilities.

70.35(11) The program shall meet the requirements in subrule 70.32(4).

[ARC 8177B, IAB 9/23/09, effective 1/1/10; ARC 2463C, IAB 3/16/16, effective 4/20/16]

481—70.36(231D) Identification of veteran's benefit eligibility.

70.36(1) Within 30 days of a participant's participation in an adult day services program that receives reimbursement through the medical assistance program under Iowa Code chapter 249A, the program shall ask the participant or the participant's personal representative whether the participant is a veteran or whether the participant is the spouse, widow or dependent of a veteran and shall document the response.

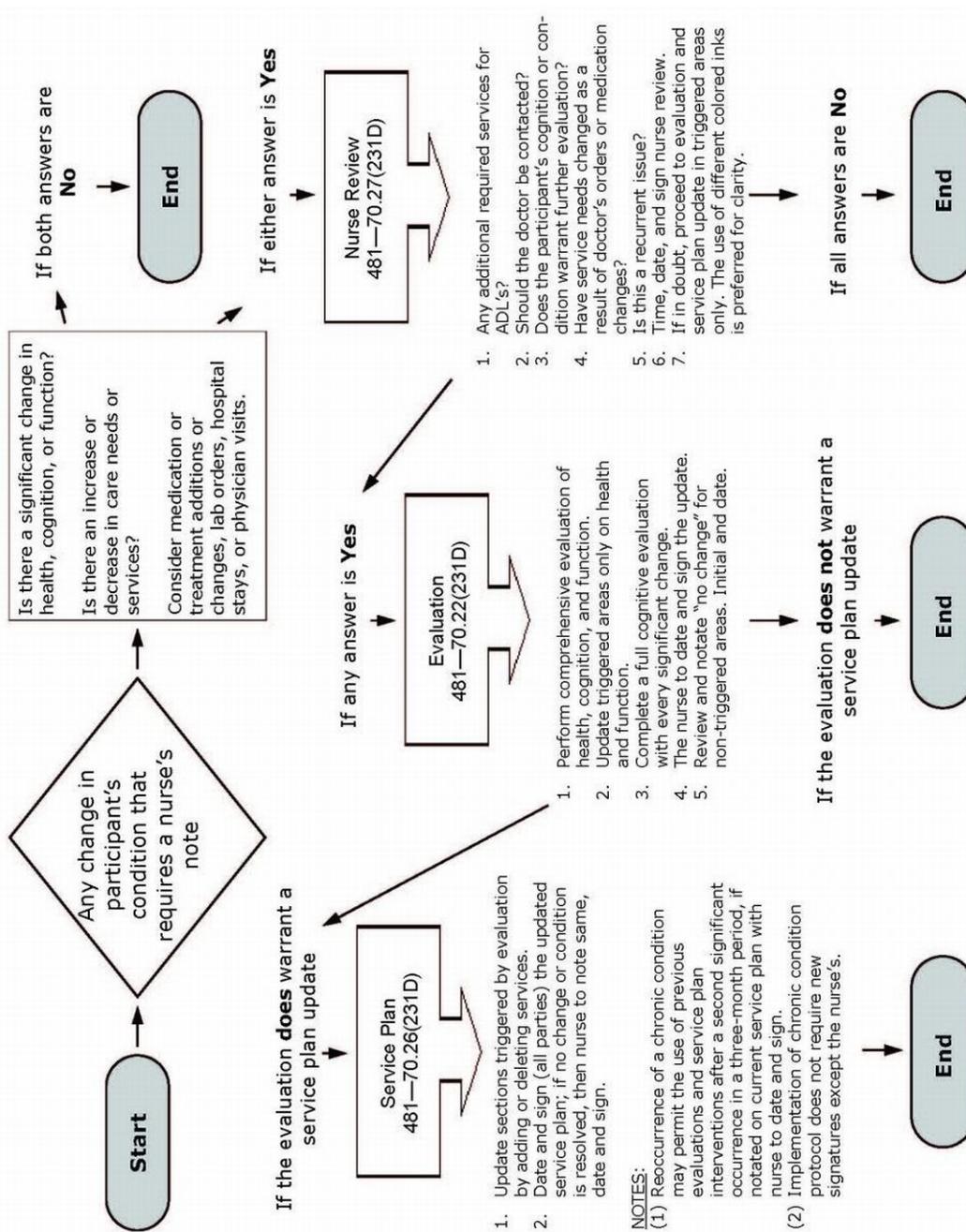
70.36(2) If the program determines that the participant may be a veteran or the spouse, widow, or dependent of a veteran, the program shall report the participant's name along with the name of the veteran, if applicable, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. When appropriate, the program may also report such information to the Iowa department of human services.

70.36(3) If a participant is eligible for benefits through the U.S. Department of Veterans Affairs or other third-party payor, the program first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

[ARC 8177B, IAB 9/23/09, effective 1/1/10]

These rules are intended to implement Iowa Code chapter 231D.

Table A



[Filed ARC 8177B (Notice ARC 7959B, IAB 7/15/09), IAB 9/23/09, effective 1/1/10]
 [Filed ARC 1376C (Notice ARC 1291C, IAB 1/22/14), IAB 3/19/14, effective 4/23/14]
 [Filed ARC 1547C (Notice ARC 1472C, IAB 5/28/14), IAB 7/23/14, effective 8/27/14]
 [Filed ARC 1927C (Notice ARC 1860C, IAB 2/4/15), IAB 4/1/15, effective 5/6/15]
 [Filed ARC 2463C (Notice ARC 2200C, IAB 10/14/15), IAB 3/16/16, effective 4/20/16]
 [Filed ARC 4976C (Notice ARC 4867C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

CHAPTER 154
MEDICAL CANNABIDIOL PROGRAM

641—154.1(124E) Definitions. For the purposes of these rules, the following definitions shall apply:

“*Acceptance criteria*” means the specified limits placed on characteristics of an item or method that are used to determine data quality.

“*Accreditation*” means the procedure by which an authoritative body gives formal recognition that an organization is competent to carry out specific tasks and verifies that the appropriate quality management system is in place.

“*Accredited nonpublic school*” means any nonpublic school accredited by the Iowa state board of education, excluding home schools.

“*Action level*” means the threshold value that provides the criterion for determining whether a sample passes or fails a test performed pursuant to these rules.

“*Aliquot*” means a portion of a sample that is used in an analysis.

“*Analyte*” means a chemical, compound, element, bacteria, yeast, fungus, or toxin to be identified or measured.

“*Analytical batch*” means a group of samples that are prepared together for the same analysis and analyzed sequentially using the same instrument calibration curve and common analytical quality control checks.

“*Analytical method*” means a technique used qualitatively or quantitatively to determine the composition of a sample or a microbial contamination of a sample.

“*Audit*” means a financial review by an independent certified public accountant that includes select scope engagement or other methods of review that analyze operational or compliance issues.

“*Background investigation*” means a thorough review of an entity, an owner, investors, and employees conducted by the department of public safety, including but not limited to state and national criminal history records, credit records, and internal revenue service records.

“*Batch*” means a specifically identified quantity of dried flower and other cannabis plant matter that is uniform in strain or cultivar, harvested at the same time, and cultivated using the same pesticides and other crop inputs.

“*Batch number*” means a unique numeric or alphanumeric identifier assigned to a batch of cannabis plants by a manufacturer when the batch is harvested. The batch number shall contain the manufacturer’s number and a sequence to allow for inventory and traceability.

“*Biosecurity*” means a set of preventative measures designed to reduce the risk of transmission of:

1. Infectious diseases in crops;
2. Quarantined pests;
3. Invasive alien species;
4. Living modified organisms.

“*Bordering state*” means the same as defined in Iowa Code section 331.910.

“*Cannabinoid*” means a chemical compound that is unique to and derived from cannabis.

“*Cannabis*” means seeds, plants, cuttings, or plant waste material from *Cannabis sativa* L. or *Cannabis indica* used in the manufacture of medical cannabidiol.

“*CAS number*” means a unique numerical identifier assigned to every chemical substance described in the open literature by Chemical Abstracts Service.

“*CBD*” means cannabidiol, Chemical Abstracts Service number 13956-29-1.

“*CBD A*” means cannabidiolic acid, Chemical Abstracts Service number 1244-58-2.

“*CBG*” means cannabigerol, Chemical Abstracts Service number 25654-31-3.

“*CBN*” means cannabiniol, Chemical Abstracts Service number 521-35-7.

“*Certificate of analysis*” means the report prepared for the requester about the analytical testing performed and the results obtained by a laboratory.

“*Certification*” means a procedure by which a third party gives written assurance (certificate of conformity) that a product, process or service conforms to specified requirements.

“*Certified*” means that a laboratory demonstrates to the satisfaction of the department its ability to consistently produce valid data within the acceptance limits as specified in the department’s requirements for certification and meets the minimum requirements of this chapter and all applicable regulatory requirements.

“*Certified reference material*” means a reference material prepared by a certifying body.

“*Crop input*” means any substance applied to or used in the cultivation and growth of a cannabis plant. “Crop input” includes, but is not limited to, pesticides, fungicides, fertilizers, and other soil or medium amendments.

“*Data-quality assessment*” means a scientific and statistical process that establishes whether the collected data are of the right type, quality, and quantity to support the intended use of the data.

“*Date of expiration*” means one year from the date of issuance of the medical cannabidiol registration card by the department of transportation.

“*Date of issuance*” means the date of issuance of the medical cannabidiol registration card by the department of transportation.

“*Debilitating medical condition*” means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn’s disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson’s disease.
9. Untreatable pain.
10. Any medical condition that is recommended by the medical cannabidiol board and adopted by the board of medicine by rule pursuant to Iowa Code section 124E.5 and that is listed in 653—subrule 13.15(1).

“*Department*” means the Iowa department of public health.

“*Department of transportation*” means the Iowa department of transportation.

“*Director*” means the director of the Iowa department of public health.

“*Dispensary*” means an individual or entity licensed by the department to dispense medical cannabidiol to patients and primary caregivers pursuant to Iowa Code chapter 124E and these rules. “Dispensary” includes the employees and agents of the dispensary.

“*Dispensary facility*” means any secured building, space, grounds, and physical structure of a dispensary licensed by the department to dispense medical cannabidiol and where the dispensing of medical cannabidiol is authorized.

“*Dispense*” or “*dispensing*” means to supply medical cannabidiol to patients pursuant to Iowa Code chapter 124E and these rules.

“*Disqualifying felony offense*” means a violation under federal or state law of a felony under federal or state law, which has as an element the possession, use, or distribution of a controlled substance, as defined in 21 U.S.C. §802(6).

“*Edible medical cannabidiol products*” means food items containing medical cannabidiol. “Edible medical cannabidiol products” does not include pills, tinctures, oils, or other forms of medical cannabidiol that may be consumed orally or through the nasal cavity that do not contain food or food

additives; provided that food or food additives used as carriers, excipients, or processing aids shall not be considered food or food additives.

“Field duplicate sample” means a sample that is taken in the identical manner and from the same batch, process lot, or lot being sampled as the primary sample. A field duplicate sample is analyzed separately from the primary sample and is used for quality control only.

“Form and quantity” means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

“Frequency” means the number of items occurring in a given category. Frequency may be determined by analytical method or laboratory-specific requirements for the purpose of accuracy, precision of the analysis, or statistical calculation.

“Health care practitioner” means an individual licensed under Iowa Code chapter 148 to practice medicine and surgery or osteopathic medicine and surgery who is a patient’s primary care provider. “Health care practitioner” shall not include a physician assistant licensed under Iowa Code chapter 148C or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 or 152E.

“Increment” or *“sample increment”* means a smaller sample that, together with other increments, makes up the primary sample.

“Inspection” means an on-site evaluation by the department, the department of public safety, or a department-approved independent consultant of facilities, records, personnel, equipment, methodology, and quality assurance practices for compliance with these rules.

“International Electrotechnical Commission” or *“IEC”* means an independent, nongovernmental membership organization that prepares and publishes international standards for all electrical, electronic, and related technologies.

“International Organization for Standardization” or *“ISO”* means an independent, nongovernmental membership organization and the largest developer of voluntary international standards.

“Investor” means a person making a cash investment of at least 5 percent interest in an applicant or licensed manufacturer or dispensary with the expectation of receiving financial returns.

“Laboratory” means the state hygienic laboratory at the University of Iowa or other independent medical cannabidiol testing facility accredited to Standard ISO/IEC 17025 by an ISO-approved accrediting body, with a controlled substance registration certificate from the Drug Enforcement Administration of the U.S. Department of Justice and a certificate of registration from the Iowa board of pharmacy, and approved by the department to examine, analyze, or test samples of medical cannabidiol or any substance used in the manufacture of medical cannabidiol.

“Limit of detection” or *“LOD”* means the lowest quantity of a substance or analyte that can be distinguished from the absence of that substance within a stated confidence limit.

“Limit of quantitation” or *“LOQ”* means the minimum concentration of an analyte in a specific matrix that can be reliably quantified while also meeting predefined goals for bias and imprecision.

“Lot” means a specific quantity of medical cannabidiol that is uniform and intended to meet specifications for identity, strength, purity, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling record.

“Lot number” means a unique numeric or alphanumeric identifier assigned to a lot by a manufacturer when medical cannabidiol is produced. The lot number shall contain the manufacturer’s number and a sequence to allow for inventory, traceability, and identification of the plant batches used in the production of a lot of medical cannabidiol.

“Manufacture” or *“manufacturing”* means the process of converting harvested cannabis plant material into medical cannabidiol.

“Manufacturer” means an individual or entity licensed by the department to produce medical cannabidiol and distribute it to dispensaries pursuant to Iowa Code chapter 124E and these rules. “Manufacturer” includes the employees and agents of the manufacturer.

“*Manufacturing facility*” means any secured building, space, grounds, and physical structure of a manufacturer for the cultivation, harvesting, packaging, processing, storage, and distribution of cannabis or medical cannabidiol and where access is restricted to designated employees of a manufacturer and escorted visitors.

“*Market withdrawal*” means the voluntary removal of medical cannabidiol from dispensaries and patients by a manufacturer for minor issues that do not pose a serious health threat.

“*Mass spectrometry*” means an analytical technique that ionizes chemical species and sorts the ions based on their mass-to-charge ratio.

“*Matrix*” means the component or substrate that contains the analyte of interest.

“*Matrix spike duplicate*” means a duplicate sample prepared by adding a known quantity of a target analyte to a field sample matrix or other matrix that is as closely representative of the matrix under analysis as possible.

“*Matrix spike sample*” means a sample prepared by adding a known quantity of the target analyte to a field sample matrix or to a matrix that is as closely representative of the matrix under analysis as possible.

“*Medical assistance program*” means IA Health Link, Medicaid Fee-for-Service, or HAWK-I, as administered by the Iowa Medicaid enterprise of the Iowa department of human services.

“*Medical cannabidiol*” means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that has a tetrahydrocannabinol level of no more than 3 percent and that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and designated in this chapter.

“*Medical cannabidiol tracking number*” means the sales identification number assigned by a dispensary to a transaction at the time of the sale of a medical cannabidiol product.

“*Medical cannabidiol waste*” means medical cannabidiol that is unused, unwanted, damaged, defective, expired, or contaminated and that is returned to a dispensary or manufacturer for disposal.

“*Medical cannabis goods*” means medical cannabidiol process lots, medical cannabidiol products, and cannabis plant material, including dried tissue.

“*Method blank*” means an analyte-free matrix to which all reagents are added in the same volumes or proportions as are used in sample preparation.

“*Moisture content*” means the percentage of water in a dry sample by weight.

“*National criminal history background check*” means fingerprint processing through the department of public safety and the Federal Bureau of Investigation (FBI) and review of records on file with national organizations, courts, and law enforcement agencies to the extent allowed by law.

“*Non-target organism*” means an organism that the test method or analytical procedure is not testing for. Non-target organisms are used in evaluating the specificity of a test method.

“*Owner*” means a person with a 5 percent or greater ownership interest in an applicant or licensed manufacturer or dispensary.

“*Patient*” means a person who is a permanent resident of the state of Iowa who suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E and these rules.

“*Patient registration number*” means the unique identification number issued to a patient by the department of transportation upon approval of a patient’s application by the department as described in these rules.

“*Percent recovery*” means the percentage of a measured concentration relative to the added (spiked) concentration in a reference material, matrix spike sample, or matrix spike duplicate.

“*Permanent resident*” means a natural person who physically resides in Iowa as the person’s principal and primary residence and who establishes evidence of such residency by providing the department with one of the following:

1. A valid Iowa driver’s license,
2. A valid Iowa nonoperator’s identification card,
3. A valid Iowa voter registration card,
4. A current Iowa vehicle registration certificate,

5. A utility bill,
6. A statement from a financial institution,
7. A residential lease agreement,
8. A check or pay stub from an employer,
9. A child's school or child care enrollment documents,
10. Valid documentation establishing a filing for homestead or military tax exemption on property located in Iowa, or
11. Other valid documentation as deemed acceptable by the department to establish residency.

"Pharmaceutical grade" means medical cannabidiol that meets standards for content, contamination, and consistency set by the department as determined by testing conducted at a laboratory pursuant to Iowa Code chapter 124E and these rules.

"Plant material" means any plant of *Cannabis sativa* L. or *Cannabis indica*, or any part thereof, including flowers, leaves, trichomes, and tissue.

"Plant material waste" means plant material that is not used in the production of medical cannabidiol in a form allowable under these rules.

"Primary caregiver" means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of Iowa Code chapter 124E and these rules.

"Primary care provider" means any health care practitioner involved in the diagnosis and treatment of a patient's debilitating medical condition.

"Primary sample" means a portion of a batch, process lot, or lot that is used for testing for identity, strength, purity, and composition.

"Process lot" means any amount of cannabinoid concentrate or extract that is uniform, produced from one or more batches, and used for testing for identity, strength, purity, and composition prior to being packaged.

"Product expiration date" means the date after which a medical cannabidiol product may not be sold by a manufacturer or a dispensary.

"Production" or *"produce"* means:

1. Cultivating or harvesting plant material;
2. Processing or manufacturing; or
3. Packaging of medical cannabidiol.

"Proficiency test" means an evaluation of a laboratory's performance against preestablished criteria by means of interlaboratory comparisons of test measurements.

"Proficiency test sample" means a sample prepared by a party independent of the testing laboratory, with a concentration and identity of an analyte that is known to the independent party but is unknown to the testing laboratory and testing laboratory personnel.

"Public or private school" means any property operated by a school district, charter school, or accredited nonpublic school for purposes related to elementary, middle, or secondary schools or secondary vocation centers.

"Qualitative analysis" means identification of an analyte in a substance or mixture.

"Quality assurance" means a set of operating principles to produce data of known accuracy and precision. "Quality assurance" encompasses employee training, equipment preventative maintenance procedures, calibration procedures, and quality control testing, among other things.

"Quality control" means a set of measures implemented within an analytical procedure to ensure that the measurement system is operating in a state of statistical control in which errors have been reduced to acceptable levels.

"Quality control samples" means samples produced and used for the purpose of assuring quality control. Quality control samples include but are not limited to blank samples, spike samples, duplicate samples, and reference material samples.

“*Quantitative analysis*” means measurement of the quantities of chemical components present in a substance or mixture. Quantitative analysis typically uses a certified reference material, if available, to create a calibration curve.

“*Reagent*” means a compound or mixture added to a system to cause a chemical reaction or to test if a reaction occurs. A reagent may be used to tell whether or not a specific chemical substance is present by causing a reaction to occur with the chemical substance.

“*Recall*” means the return of medical cannabidiol from patients and dispensaries to a manufacturer because of the potential for serious health consequences from the use of the medical cannabidiol.

“*Reference material*” means a material containing a known concentration of an analyte of interest that is in solution or in a homogeneous matrix. Reference material is used to document the bias of the analytical process.

“*Reference method*” means a method by which the performance of an alternate method is measured or evaluated.

“*Relative percent difference*” or “*RPD*” means a comparative statistic used to calculate precision or random error. RPD is calculated using the following equation: $RPD = \frac{\text{absolute value (primary sample measurement - duplicate sample measurement)}}{([\text{primary sample measurement} + \text{duplicate sample measurement}] / 2)} \times 100$.

“*Relative standard deviation*” or “*RSD*” means the standard deviation expressed as a percentage of the mean recovery. “*RSD*” is the coefficient of variation multiplied by 100. If any results are less than the limit of quantitation, then the absolute value of the limit of quantitation is used in the following equation: $RSD = (s / x) \times 100$, where s = standard deviation and x = mean recovery.

“*Requester*” means a person who submits a request to a licensed testing laboratory for state-mandated testing of medical cannabis goods. The requester may be a licensed manufacturer or the department.

“*Residual solvents and processing chemicals*” means volatile organic chemicals that are used or produced in the manufacture or production of medical cannabidiol.

“*Restricted access area*” means a building, room, or other contiguous area on the premises where plant material is grown, cultivated, harvested, stored, packaged, or processed for sale under control of the manufacturer, and where no person under the age of 18 is permitted.

“*Sample*” means a representative part of or a single item from a larger whole or group.

“*Sanitize*” means to sterilize, disinfect, or make hygienic.

“*Semiquantitative analysis*” means less than quantitative precision and does not involve a full calibration. Analyte identification is based on a single-point reference or high-probability library match. The determination of amount uses the ratio of the unknown chemical analyte to that of a known analyte added to the sample before analysis. Uncertainty for semiquantitative results is higher than for quantitative results.

“*Significant figures*” means the number of digits used to express a measurement.

“*Stability*” or “*stable*” means that after storage of an unopened package of medical cannabidiol at a licensed manufacturing facility or dispensary facility, the contents shall not vary in concentrations of THC and CBD by more than an amount determined by the department and listed in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).

“*Standard operating procedure*” means a written document that provides detailed instructions for the performance of all aspects of an analysis, operation, or action.

“*State*” means a state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

“*Synthetic cannabinoid*” means a designed compound with structural features that allow binding to the known cannabinoid receptors present in human cells and that produce biological effects similar to those of natural cannabinoids.

“*Tamper-evident*” means that one or more one-time-use seals are affixed to the opening of a package, allowing a person to recognize whether or not the package has been opened.

“*Target organism*” means an organism that is being tested for in an analytical procedure or test method.

“*Testing laboratory record*” means information relating to the testing laboratory and the analyses it performs that is prepared, owned, used, or retained by the laboratory and includes electronic files and video footage.

“*THC*” or “*delta-9 THC*” means tetrahydrocannabinol, Chemical Abstracts Service number 1972-08-3.

“*THCA*” means tetrahydrocannabinolic acid, Chemical Abstracts Service number 23978-85-0.

“*Untreatable pain*” means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

“*Validation*” means the confirmation by examination and objective evidence that the particular requirements for a specific intended use are fulfilled.

“*Written certification*” means a document signed by a health care practitioner, with whom the patient has established a patient-provider relationship, which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter; ARC 4928C, IAB 2/12/20, effective 6/1/20; see correction note at end of chapter]

REGISTRATION CARDS

641—154.2(124E) Health care practitioner certification—duties and prohibitions.

154.2(1) Prior to a patient’s submission of an application for a medical cannabidiol registration card pursuant to this rule, a health care practitioner shall do all of the following:

a. Determine, in the health care practitioner’s medical judgment, whether the patient whom the health care practitioner has examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol as defined by this chapter, and if so determined, provide the patient with a written certification of that diagnosis by completing the health care practitioner section of the application form provided for this purpose on the department’s website (www.idph.iowa.gov).

b. Provide explanatory information to the patient as provided on the department’s website (www.idph.iowa.gov) about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

154.2(2) Subsequently, the health care practitioner shall do the following:

a. Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.

b. Otherwise comply with all requirements in this chapter and requests from the department for more information.

154.2(3) A health care practitioner may provide, but has no duty to provide, a written certification pursuant to this rule.

154.2(4) Health care practitioner prohibitions.

a. A health care practitioner shall not accept, solicit, or offer any form of remuneration from or to any individual, including but not limited to a patient, a primary caregiver, or an employee, investor, or owner of a medical cannabidiol manufacturer or dispensary, to certify a patient’s condition, other than accepting a fee for a patient consultation to determine if the patient should be issued a certification of a qualifying debilitating medical condition.

b. A health care practitioner shall not accept, solicit, or offer any form of remuneration from or to any individual, including but not limited to a patient, a primary caregiver, or an employee, investor, or owner of a medical cannabidiol manufacturer or dispensary, to certify an individual as a primary caregiver for a patient with respect to the use of medical cannabidiol, other than accepting a fee for a consultation to determine if the individual is a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol.

c. A health care practitioner shall not advertise certifying a qualifying debilitating medical condition as one of the health care practitioner’s services.

d. A health care practitioner shall not certify a qualifying debilitating medical condition for a patient who is the health care practitioner or a family or household member of the health care practitioner.

e. A health care practitioner shall not be designated to act as a primary caregiver for a patient for whom the health care practitioner has certified a qualifying debilitating medical condition.

f. A health care practitioner shall not receive or provide medical cannabidiol product samples. [ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.3(124E) Medical cannabidiol registration card—application and issuance to patient.

154.3(1) Subject to subrule 154.3(7), the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a patient who:

a. Is at least 18 years of age.

b. Is a permanent resident of Iowa.

c. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(124E) and signed by the patient’s health care practitioner certifying that the patient is suffering from a debilitating medical condition.

d. Submits an application to the department, on a form created by the department in consultation with the department of transportation and available at the department’s website (www.idph.iowa.gov), that contains all of the following:

(1) The patient’s full legal name, Iowa residence address, mailing address (if different from the patient’s residence address), telephone number, date of birth, and sex designation. The patient shall not provide as a mailing address an address for which a forwarding order is in place.

(2) A copy of the patient’s valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver’s license,

2. A valid Iowa nonoperator’s identification card, or

3. An alternative form of valid photo identification. A patient who possesses or is eligible for an Iowa driver’s license or an Iowa nonoperator’s identification card shall present such document as valid photo identification. A patient who is ineligible to obtain an Iowa driver’s license or an Iowa nonoperator’s identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A patient who applies for an exemption is subject to verification of the patient’s identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(3) Full name, address, and telephone number of the patient’s health care practitioner.

(4) Full legal name, residence address, date of birth, and telephone number of each primary caregiver of the patient, if any.

(5) An attestation as to the truthfulness and accuracy of the information provided by the patient on the application.

e. Has not been convicted of a disqualifying felony offense.

f. Submits the required fee, as described in subrule 154.12(1).

154.3(2) Upon the completion, verification, and approval of the patient’s application and the receipt of the required fee, the department shall notify the department of transportation that the patient may be issued a medical cannabidiol registration card.

154.3(3) A medical cannabidiol registration card issued to a patient by the department of transportation shall contain all of the following:

a. The patient’s full legal name, Iowa residence address, date of birth, and sex designation, as shown on the patient’s Iowa driver’s license, nonoperator’s identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) “*d*”(2)“3.” If the patient’s name, Iowa residence address, date of birth, or sex designation has changed since the issuance of the patient’s Iowa driver’s license, nonoperator’s identification card, or alternative form of valid photo identification, the patient shall first update the patient’s Iowa driver’s license or nonoperator’s identification card to reflect the current information, according to the procedures set forth in 761—subrule 605.11(2), 761—subrule

605.25(4), or rule 761—630.3(321), or shall update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the patient's social security number.

d. The patient's signature. The signature shall be without qualification and shall contain only the patient's usual signature without any other titles, characters, or symbols. The patient's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the patient's application for a medical cannabidiol registration card are true and correct. The patient's signature shall be captured electronically.

e. A color photograph of the patient.

f. A statement that the medical cannabidiol registration card is not valid for identification purposes.

154.3(4) Every patient 18 years of age or older must obtain a valid medical cannabidiol registration card to use medical cannabidiol in Iowa. The department may waive this requirement for a patient who is unable to obtain a card because of health, mobility, or other issues, but only when the patient:

a. Has submitted an application for a medical cannabidiol registration card;

b. Has had the application approved by the department;

c. Has been assigned a patient registration number;

d. Has designated a primary caregiver whose application has been approved and whose medical cannabidiol registration card has been issued; and

e. Complies with all provisions of Iowa Code chapter 124E.

154.3(5) An authorization to use medical cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E or these rules for the issuance of a medical cannabidiol registration card.

154.3(6) A valid medical cannabidiol registration card, or its equivalent, issued under the laws of another state that allow an out-of-state patient to possess or use medical cannabidiol in the jurisdiction of issuance shall have the same force and effect as a valid medical cannabidiol registration card issued pursuant to Iowa Code chapter 124E, except that an out-of-state patient in Iowa shall not obtain medical cannabidiol from a medical cannabidiol dispensary in Iowa.

154.3(7) The department shall not approve the issuance of a medical cannabidiol registration card for a patient who is enrolled in a federally approved clinical trial for the treatment of a debilitating medical condition with medical cannabidiol.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.4(124E) Medical cannabidiol registration card—application and issuance to primary caregiver.

154.4(1) For a patient in a primary caregiver's care, the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a primary caregiver who:

a. Is at least 18 years of age.

b. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(124E) and signed by the patient's health care practitioner certifying that the patient is suffering from a debilitating medical condition.

c. Submits an application as a primary caregiver for each patient for whom the person is the primary caregiver. The primary caregiver application must be on a form created by the department in consultation with the department of transportation and available at the department's website (www.idph.iowa.gov) that contains all of the following:

(1) The primary caregiver's full legal name, residence address, mailing address (if different from the primary caregiver's residence address), telephone number, date of birth, and sex designation. The primary caregiver shall not provide as a mailing address an address for which a forwarding order is in place.

(2) The patient's full legal name, date of birth, and parent or legal guardian's name if the patient is under the age of 18.

(3) A copy of the primary caregiver's valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver's license,
2. A valid Iowa nonoperator's identification card,
3. If the primary caregiver is not a resident of the state of Iowa, a valid state-issued driver's license or nonoperator's identification card issued by a state other than Iowa, or
4. An alternative form of valid photo identification. A primary caregiver who possesses or is eligible for a driver's license or a nonoperator's identification card shall present such document as valid photo identification. A primary caregiver who is ineligible to obtain a driver's license or a nonoperator's identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A primary caregiver who applies for an exemption is subject to verification of the primary caregiver's identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(4) Full name, address, and telephone number of the patient's health care practitioner.

(5) An attestation as to the truthfulness and accuracy of the information provided by the primary caregiver on the application.

d. Has not been convicted of a disqualifying felony offense.

e. Submits the required fee, as described in subrule 154.12(2).

154.4(2) Upon the completion, verification, and approval of the primary caregiver's application, the department shall notify the department of transportation that the primary caregiver may be issued a medical cannabidiol registration card.

154.4(3) A medical cannabidiol registration card issued to a primary caregiver by the department of transportation shall contain all of the following:

a. The primary caregiver's full legal name, current residence address, date of birth, and sex designation, as shown on the primary caregiver's state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.4(1) "c"(3) "4." If the primary caregiver's name, current residence address, date of birth, or sex designation has changed since issuance of the primary caregiver's Iowa-issued driver's license, nonoperator's identification card, or other form of valid photo identification, the primary caregiver shall first update the primary caregiver's Iowa-issued driver's license or nonoperator's identification card according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321) or update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the primary caregiver's social security number.

d. The medical cannabidiol registration number for each patient in the primary caregiver's care. This number shall not be the primary caregiver's or patient's social security number. If the patient in the primary caregiver's care is under the age of 18, the full name of the patient's parent or legal guardian shall be printed on the primary caregiver's registration card in lieu of the patient's medical cannabidiol registration number.

e. The primary caregiver's signature. The signature shall be without qualification and shall contain only the primary caregiver's usual signature without any other titles, characters, or symbols. The primary caregiver's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the primary caregiver's application for a medical cannabidiol registration card are true and correct. The primary caregiver's signature shall be captured electronically.

f. A color photograph of the primary caregiver.

g. A statement that the medical cannabidiol registration card is not valid for identification purposes.

h. A statement distinguishing the medical cannabidiol registration cardholder as a primary caregiver.

154.4(4) A patient who is 18 years of age or older must have an approved application and a distinguishing medical cannabidiol registration number that is not the patient's social security number prior to the issuance of a medical cannabidiol registration card to the patient's primary caregiver.

154.4(5) An authorization to use, or to act as a primary caregiver for a patient authorized to use, cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E or these rules for the issuance of a medical cannabidiol registration card.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.5(124E) Tamperproofing. The department of transportation shall issue a medical cannabidiol registration card by a method or process which prevents as nearly as possible the alteration, reproduction, or superimposition of a photograph on the cannabidiol registration card without ready detection.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.6(124E) Denial and cancellation. The department may deny an application for a medical cannabidiol registration card, or may cancel or direct the department of transportation to cancel a medical cannabidiol registration card, for any of the following reasons:

1. Information contained in the application is illegible, incomplete, falsified, misleading, deceptive, or untrue.

2. The department or the department of transportation is unable to verify the identity of the applicant from the photo identification or other documentation presented pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4."

3. The applicant violates or fails to satisfy any of the provisions of Iowa Code chapter 124E or these rules.

4. A patient, the patient's legal guardian, or other person with durable power of attorney requests in writing that the department cancel the patient's medical cannabidiol registration card. The department shall notify a primary caregiver in writing when the registration card of the primary caregiver's patient has been canceled.

5. A primary caregiver requests in writing that the department cancel the primary caregiver's medical cannabidiol registration card. The department shall notify a patient in writing when the registration card of the patient's primary caregiver has been canceled.

6. The department becomes aware of the death of a patient or primary caregiver.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.7(124E) Appeal. If the department denies an application for or cancels a medical cannabidiol registration card, the department shall inform the applicant or cardholder of the denial or cancellation and state the reasons for the denial or cancellation in writing. An applicant or cardholder may appeal the denial or cancellation of a medical cannabidiol registration card by submitting a request for appeal to the department by certified mail, return receipt requested, within 20 days of receipt of the notice of denial or cancellation. The department's address is Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075. Upon receipt of a request for appeal, the department shall forward the request within five working days to the department of inspections and appeals. A contested case hearing shall be conducted in accordance with 641—Chapter 173.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.8(124E) Duplicate card.

154.8(1) Lost, stolen, or destroyed card. To replace a medical cannabidiol registration card that is lost, stolen, or destroyed, a cardholder shall present to the department of transportation the cardholder's

valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4."

154.8(2) *Change in card information and voluntary replacement.*

a. To replace a medical cannabidiol registration card that is damaged, the cardholder shall surrender to the department of transportation the card to be replaced and present the cardholder's valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4."

b. A patient or primary caregiver to whom a medical cannabidiol registration card is issued shall notify the department of a change in current residence address, name, or sex designation listed on the card, within ten calendar days of the change. To replace a medical cannabidiol registration card to change the current residence address, name, or sex designation listed on the card, the cardholder shall surrender to the department of transportation the card to be replaced and present a valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1) "d"(2)"3" or 154.4(1) "c"(3)"4" that has been updated according to the procedures established by the state or agency of issuance to reflect the requested residence address, name, or sex designation.

c. To replace a medical cannabidiol registration card held by a primary caregiver to change, add, or remove a patient's medical cannabidiol registration number or the name of a patient's parent or legal guardian listed on the primary caregiver's card, the primary caregiver shall submit a new application to the department pursuant to rule 641—154.4(124E). A medical cannabidiol registration card issued pursuant to this paragraph shall not be considered a duplicate card.

154.8(3) *Expiration date.* A duplicate medical cannabidiol registration card shall have the same expiration date as the medical cannabidiol registration card being replaced, changed, or amended.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.9(124E) *Renewal.* A medical cannabidiol registration card shall be valid for one year from the date of issuance unless canceled pursuant to rule 641—154.6(124E).

154.9(1) A cardholder seeking renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department at least 60 days prior to the date of expiration.

a. A patient applying for renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

b. A primary caregiver applying for a renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

154.9(2) A cardholder who fails to renew the medical cannabidiol registration card may not lawfully possess medical cannabidiol pursuant to this chapter.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.10(124E) *Confidentiality.* The department shall maintain a confidential file of the names of each patient to or for whom the department approves the issuance of a medical cannabidiol registration card and the name of each primary caregiver to whom the department issues a medical cannabidiol registration card under Iowa Code section 124E.4.

154.10(1) Personally identifiable information of patients and primary caregivers shall be maintained as confidential and is not accessible to the public. The department and the department of transportation shall release aggregate and statistical information regarding the medical cannabidiol act registration card program in a manner which prevents the identification of any patient or primary caregiver.

154.10(2) Personally identifiable information of patients and primary caregivers may be disclosed under the following limited circumstances:

a. To authorized employees or agents of the department and the department of transportation as necessary to perform the duties of the department and the department of transportation pursuant to Iowa Code chapter 124E.

b. To authorized employees of state or local law enforcement agencies located in Iowa, solely for the purpose of verifying that a person is lawfully in possession of a medical cannabidiol registration card issued pursuant to Iowa Code chapter 124E.

c. To a patient, primary caregiver, or health care practitioner, upon written authorization of the patient or primary caregiver.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.11(124E) Agreement with department of transportation. The department may enter into a chapter 28E agreement with the department of transportation to facilitate the issuance of medical cannabidiol registration cards. The agreement may include provisions which govern the issuance, denial, and cancellation of medical cannabidiol registration cards, the sharing of information between the department and the department of transportation, and reimbursement for costs incurred by the department of transportation for issuing the card.

[ARC 1640C, IAB 10/1/14, effective 1/30/15; ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.12(124E) Fees. All fees are nonrefundable.

154.12(1) Patient medical cannabidiol registration card fee.

a. Each application fee is \$100 unless the patient qualifies for a reduced fee as described in paragraph 154.12(1)“b.”

b. Each reduced application fee is \$25 if the patient attests to receiving social security disability benefits, supplemental security income payments, or is enrolled in the medical assistance program as defined in rule 641—154.1(124E).

c. Each renewal fee is the same as the initial card application fee.

154.12(2) Primary caregiver medical cannabidiol registration card fee.

a. Each application fee is \$25.

b. Each renewal fee is \$25.

[ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.13(124E) Use of medical cannabidiol—smoking prohibited. A patient shall not consume medical cannabidiol possessed or used pursuant to Iowa Code chapter 124E by smoking medical cannabidiol.

[ARC 3150C, IAB 7/5/17, effective 6/13/17]

641—154.14(124E) Form and quantity of medical cannabidiol. The form and quantity of medical cannabidiol authorized in this rule may be modified pursuant to recommendations by the medical cannabidiol board, subsequent approval of the recommendations by the board of medicine and adoption of the recommendations by the department by rule.

154.14(1) Quantity. A 90-day supply is the maximum amount of each product that shall be dispensed by a dispensary at one time.

154.14(2) Form.

a. A manufacturer may only manufacture medical cannabidiol in the following forms:

(1) Oral forms, including but not limited to:

1. Tablet.
2. Capsule.
3. Liquid.
4. Tincture.
5. Sublingual.

(2) Topical forms, including but not limited to:

1. Gel.
2. Ointment, cream or lotion.
3. Transdermal patch.

(3) Inhaled forms, limited to:

1. Nebulizable.
2. Vaporizable.

(4) Rectal/vaginal forms, including but not limited to suppository.

b. A manufacturer may not produce medical cannabidiol in any form that may be smoked.

c. A manufacturer may not produce medical cannabidiol in an edible form as defined in rule 641—154.1(124E).

[ARC 3150C, IAB 7/5/17, effective 6/13/17; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4399C, IAB 4/10/19, effective 5/15/19]

641—154.15 Reserved.

MANUFACTURING

641—154.16(124E) Duties of the department.

154.16(1) *Interagency agreements.* The department may enter into any interagency agreements with other state agencies for technical services or other assistance related to the regulation or inspection of manufacturers.

154.16(2) *Notice to law enforcement.* The department shall notify local law enforcement agencies and the department of public safety of the locations of manufacturers. If the department determines there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety of any conditions that pose a threat to public safety, including but not limited to:

- a. Loss or theft of medical cannabidiol or plant material;
- b. Diversion or potential diversion of medical cannabidiol or plant material;
- c. Unauthorized access to the secure sales and inventory tracking system or other patient and caregiver information system or file; or
- d. Other violations of law.

154.16(3) *Inspection of manufacturers.* The department or its agents shall conduct regular inspections of manufacturers and manufacturing facilities as described in rule 641—154.28(124E).

154.16(4) *Establishment and maintenance of a secure sales and inventory tracking system.* The department shall establish and maintain a secure, electronic system that is available 24 hours a day, seven days a week to track:

- a. Inventory of plant material, medical cannabidiol, and waste material;
- b. Transport of plant material, waste material, and laboratory samples;
- c. Application and use of crop inputs and other solvents and chemicals;
- d. Sales of medical cannabidiol to dispensaries;
- e. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

154.16(5) *Licensure and licensure renewal of manufacturers.* The department shall issue a request for proposals to select and license by December 1, 2017, up to two manufacturers to manufacture and to possess, cultivate, harvest, transport, package, process, and supply medical cannabidiol within the state consistent with the provisions of Iowa Code chapter 124E and these rules.

a. To be eligible for licensure, an applicant manufacturer shall provide information on forms and in a manner required by the department of public safety for the completion of a background investigation. In addition, the applicant manufacturer shall submit to the department of public safety necessary funds to satisfy the full reimbursement of costs associated with completing the background investigations. If an applicant manufacturer is not found suitable for licensure as a result of the background investigation, a license shall not be issued by the department.

b. As a condition for licensure, an applicant manufacturer shall agree to begin supplying medical cannabidiol to licensed medical cannabidiol dispensaries in Iowa no later than December 1, 2018.

c. The initial license to manufacture medical cannabidiol shall be valid from December 1, 2017, through November 30, 2018. The license shall be renewed annually unless a manufacturer relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.

d. A license to manufacture issued by the department pursuant to these rules is not assignable or transferable.

e. The department shall consider the following factors in determining whether to select and license a medical cannabidiol manufacturer:

- (1) The technical expertise of an applicant manufacturer regarding medical cannabidiol;

(2) The qualifications of an applicant manufacturer's employees;
(3) The long-term financial stability of an applicant manufacturer;
(4) The ability to provide appropriate security measures on the premises of an applicant manufacturer;

(5) Whether an applicant manufacturer has demonstrated an ability to meet certain medical cannabidiol production needs for medical use regarding the range of recommended dosages for each debilitating medical condition, the range of chemical compositions of any plant of the genus cannabis that will likely be medically beneficial for each of the debilitating medical conditions, and the form or forms of medical cannabidiol that may be appropriate for the approved debilitating medical conditions;

(6) An applicant manufacturer's projection of and ongoing assessment of wholesale product costs.

f. Pursuant to Iowa Code section 124E.6(1) "b," information submitted during the application process shall be confidential until the licensure process is completed unless otherwise protected from disclosure under state or federal law.

g. A licensed manufacturer shall submit an application to renew its license with the department at least six months before the license expires. The application shall be submitted on a form created by the department.

h. The department shall notify a manufacturer of the decision to approve or deny the manufacturer's license by August 1 of the year in which the renewal application is submitted.

154.16(6) Collection of fees from manufacturers. Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.

a. Fees to the department.

(1) Each application for licensure as a manufacturer shall include a nonrefundable application fee of \$7,500.

(2) Licensed manufacturers shall pay an annual fee to the department to cover costs associated with regulating and inspecting manufacturers and for other expenses necessary for the administration of the medical cannabidiol program. The department shall assess the fee with the notice of approval of license renewal each year by August 1, payable by the manufacturer to the department no later than December 1.

b. Fees to the department of public safety.

(1) An applicant manufacturer shall be responsible to reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure and operation as a licensed manufacturer. The department of public safety shall retain the right to bill a manufacturer for additional background investigations, as needed.

(2) Each manufacturer submitting an application for licensure shall, at the time of application, submit to the department of public safety a deposit of \$10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer.

(3) A licensed manufacturer shall pay a deposit of \$200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the manufacturer. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the manufacturer shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

154.16(7) Recall of medical cannabidiol products. Medical cannabidiol products may be recalled in the following ways:

a. By manufacturer. Recalls may be undertaken voluntarily and at any time by a licensed manufacturer.

b. By department. If the department determines, based on an evaluation of the health hazard presented, that there is a reasonable probability that use of, or exposure to, a violative medical cannabidiol product will cause a serious adverse health consequence or death, the department may require a manufacturer to recall such violative medical cannabidiol products from dispensaries. An evaluation of the health hazard presented by medical cannabidiol being considered for recall shall be conducted by an ad hoc committee of scientists appointed by the director of the department and shall take into account, but need not be limited to, each of the following factors:

(1) Whether any disease or injuries have already occurred from the use of the medical cannabidiol.
(2) Whether any existing conditions could contribute to a clinical situation that could expose humans to a health hazard. Any conclusion shall be supported as completely as possible by scientific documentation and/or statements that the conclusion is the opinion of the individual(s) making the health hazard determination.

(3) Assessment of hazard to various segments of the population, e.g., children, who are expected to be exposed to the product being considered, with particular attention paid to the hazard to those individuals who may be at greatest risk.

(4) Assessment of the degree of seriousness of the health hazard to which the populations at risk would be exposed.

(5) Assessment of the likelihood of occurrence of the hazard.

(6) Assessment of the consequences (immediate or long-range) of occurrence of the hazard.

(7) The findings of the department during a directed inspection of the licensed manufacturing facility.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter; ARC 4928C, IAB 2/12/20, effective 6/1/20; see correction note at end of chapter]

641—154.17(124E) Manufacturer operations.

154.17(1) Operating documents.

a. A manufacturer shall maintain operating documents that accurately reflect the manufacturer's standard operating procedures. Unless otherwise noted, a manufacturer shall make the operating documents available to the department upon request through secure electronic mail, an electronic file-sharing service, or other secure means.

b. The operating documents of a manufacturer shall include all of the following:

(1) Procedures for the oversight of the manufacturer, including descriptions of operational and management practices regarding:

1. The forms and quantities of medical cannabidiol products that are produced at the manufacturing facility;

2. The methods of planting, harvesting, drying, and storing cannabis. A manufacturer may make operating documents for these procedures available on site only;

3. The estimated types and amounts of all crop inputs used in the production of medical cannabidiol;

4. The estimated types and amounts of medical cannabidiol waste and plant material waste to be generated;

5. The disposal methods for all waste materials;

6. Employee training methods for the specific phases of production. A manufacturer may make operating documents for these procedures available on site only;

7. Biosecurity measures and standard operating procedures used in the production and manufacturing of medical cannabidiol. A manufacturer may make operating documents for these procedures available on site only;

8. Strategies for identifying and reconciling discrepancies in inventory of plant material or medical cannabidiol;

9. Sampling strategy and quality testing for labeling purposes. A manufacturer may make operating documents for these procedures available on site only;

10. Medical cannabidiol packaging and labeling procedures;

11. Procedures for recall and market withdrawal of medical cannabidiol;

12. Plans for responding to a security breach at a manufacturing facility or while medical cannabidiol is in transit to a dispensary. A manufacturer may make operating documents for these procedures available on site only;

13. A business continuity plan. A manufacturer may make this operating document available on site only;

14. Records relating to all transport activities; and

15. Other information requested by the department.

(2) Procedures to ensure accurate record keeping.

(3) Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas containing medical cannabidiol. A manufacturer may make operating documents for these procedures available on site only.

c. Operating documents may be trade secrets if designated as such by a manufacturer and shall be considered confidential records pursuant to Iowa Code section 22.7(3).

154.17(2) *Prohibited activities.* A manufacturer shall not:

a. Own or operate a medical cannabidiol manufacturing facility unless the manufacturer is licensed by the department pursuant to Iowa Code chapter 124E and these rules;

b. Produce or manufacture medical cannabidiol in any location except in those areas approved by the department;

c. Sell, deliver, transport, or distribute medical cannabidiol from any location except its manufacturing facility or a dispensary facility;

d. Produce or manufacture medical cannabidiol in Iowa for sales or distribution outside of Iowa;

e. Sell or distribute medical cannabidiol to any person or business other than a dispensary;

f. Refuse to sell, deliver, transport, or distribute medical cannabidiol in any form or quantity produced by the manufacturer to a dispensary, unless deemed appropriate in the manufacturer's reasonable business judgment and approved by the department in writing;

g. Transport or deliver medical cannabidiol to any location except as allowed in subrule 154.22(1);

h. Sell medical cannabidiol that is not packaged and labeled in accordance with rule 641—154.21(124E);

i. Sell medical cannabidiol in any form or quantity other than a form or quantity approved by the department, subject to recommendation by the medical cannabidiol board and approval by the board of medicine;

j. Permit any person to consume medical cannabidiol on the property of the manufacturer;

k. Employ a person who is under 18 years of age or who has been convicted of a disqualifying felony offense;

l. Manufacture edible medical cannabidiol products.

154.17(3) *Criminal background investigations.*

a. A manufacturer shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history record check.

b. An employee of a manufacturer shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

c. An applicant or licensed manufacturer shall respond within 30 days to a request from the department or the department of public safety for more information to complete a background investigation and national criminal history background check on an owner, investor, or employee.

154.17(4) *Relationship to health care practitioners.* A manufacturer shall not share office space with, refer patients to, or have any financial relationship with a health care practitioner.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.18(124E) Security requirements. The department may request assistance from the department of public safety in ensuring manufacturers meet the security requirements in this rule.

154.18(1) Visitor logs. Visitors to the manufacturing facility shall sign visitor manifests with name, date, and times of entry and exit, and shall wear badges that are visible at all times and that identify them as visitors.

154.18(2) Restricted access. A manufacturer shall use a controlled access system and written manifests to limit entrance to all restricted access areas of its manufacturing facility and shall retain a record of all persons who entered the restricted access areas.

a. The controlled access system shall do all of the following:

- (1) Limit access to authorized individuals;
- (2) Maintain a log of individuals with approved access, including dates of approvals and revocations;
- (3) Track times of personnel entry to and exit from the facility;
- (4) Store data for retrieval for a minimum of one year; and
- (5) Limit access to authorized individuals in the event of a power failure.

b. Separate written manifests of visitors to restricted access areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted access areas.

c. A manufacturer shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

d. Restricted access areas shall be identified with signs that state: “Do Not Enter – Restricted Access Area – Access Limited to Authorized Personnel Only.”

154.18(3) Perimeter intrusion detection system.

a. Computer-controlled video surveillance system. A manufacturer shall operate and maintain in good working order a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days a week, and visually records:

- (1) All phases of medical cannabidiol production;
- (2) All areas that might contain plant material and medical cannabidiol, including all safes and vaults;
- (3) All points of entry and exit;
- (4) The entrance to the video surveillance control room; and
- (5) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. Camera specifications. Cameras shall:

- (1) Capture clear and certain identification of any person entering or exiting a manufacturing facility or its parking areas to the extent identification is technologically feasible with generally accepted commercial security cameras;
- (2) Have the ability to produce a clear, color still photograph live or from a recording;
- (3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
- (4) Continue to operate during a power outage.

c. Video recording specifications.

- (1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.
- (2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.
- (3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.
- (4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A manufacturer shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A manufacturer shall ensure that recordings from all video cameras are:

- (1) Available for viewing by the department upon request;
- (2) Retained for at least 60 days;
- (3) Maintained free of alteration or corruption; and
- (4) Retained longer, as needed, if a manufacturer is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

f. Required signage. A manufacturer shall post a sign in capital letters in a conspicuous location at every entrance to the manufacturing facility that reads, "THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE."

154.18(4) Security alarm system requirements.

a. A manufacturer shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:

- (1) Facility entrances and exits;
- (2) Rooms with exterior windows;
- (3) Rooms with exterior walls;
- (4) Roof hatches;
- (5) Skylights; and
- (6) Storage rooms.

b. For the purposes of this subrule, a security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:

- (1) Hardwired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal;
- (2) Motion detectors;
- (3) Pressure switches;
- (4) A duress alarm;
- (5) A panic alarm;
- (6) A holdup alarm;
- (7) An automatic voice dialer; and
- (8) A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.

c. A manufacturer's security alarm system and all devices shall continue to operate during a power outage.

d. A manufacturer's security alarm system shall be inspected and all devices tested annually by a qualified alarm vendor. A manufacturer shall provide documentation of the annual inspection and device testing to the department upon request.

154.18(5) Personnel identification system. A manufacturer shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the manufacturing facility and that meets the requirements of this subrule and subrule 154.18(1).

a. Requirement for employee identification card. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance and expiration;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A manufacturer's employee shall keep the identification card visible at all times when the employee is in a manufacturing facility, a dispensary, or a vehicle transporting medical cannabidiol.

c. Upon termination or resignation of an employee, a manufacturer shall immediately:

- (1) Revoke the employee's access to the manufacturing facility; and
- (2) Obtain and destroy the employee's identification card, if possible.

641—154.19(124E) Location. All of a manufacturer's manufacturing, cultivating, harvesting, packaging, processing, and storage of medical cannabidiol shall take place in one secured manufacturing facility location at a physical address provided to the department during the licensure and application processes.

154.19(1) Proximity to dispensary. A manufacturer shall not operate a manufacturing facility at the same physical location as a medical cannabidiol dispensary.

154.19(2) Proximity to school. A manufacturer shall not operate a manufacturing facility in any location, whether for manufacturing, possessing, cultivating, harvesting, transporting, packaging, processing, storing, or supplying, within 1,000 feet of a public or private school existing before the date of the manufacturer's licensure by the department.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.20(124E) Advertising and marketing.

154.20(1) Permitted marketing and advertising activities.

a. A manufacturer may:

(1) Display the manufacturer's business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:

1. Images of cannabis or cannabis-use paraphernalia;
2. Colloquial references to cannabis;
3. Names of cannabis plant strains or varieties;
4. Unsubstantiated medical claims; or
5. Medical symbols that bear a reasonable resemblance to established medical associations.

Examples of established medical organizations include the American Medical Association or American Academy of Pediatrics. The use of medical symbols is subject to approval by the department;

(2) Display signs on the manufacturing facility; and

(3) Maintain a business website that contains the following information:

1. The manufacturer's name and contact information;
2. The medical cannabidiol forms and quantities manufactured in Iowa; and
3. Other information as approved by the department.

b. The business website shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

c. The department reserves the right to review a manufacturer's marketing and advertising materials and to require a manufacturer to make changes to the content. The department has 30 calendar days following submission to approve or deny marketing and advertising materials of a manufacturer.

154.20(2) Other marketing and advertising activities. A manufacturer shall request and receive the department's written approval before beginning marketing or advertising activities that are not specified in subrule 154.20(1). The department has 30 calendar days to approve, deny, or request additional information regarding marketing and advertising activity requests from a manufacturer. In the event the department fails to respond to a manufacturer within 30 days with an approval, denial, or request for additional information, the manufacturer's marketing and advertising activity requests shall be deemed approved.

154.20(3) Inconspicuous display. A manufacturer shall arrange displays of medical cannabidiol, interior signs, and other exhibits to reasonably prevent public viewing from outside the manufacturing facility.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.21(124E) Packaging and labeling.

154.21(1) Medical cannabidiol packaging. A manufacturer shall package all medical cannabidiol intended for distribution according to the following standards:

a. The manufacturer shall properly package medical cannabidiol in compliance with the United States Poison Prevention Packing Act regarding child-resistant packaging and exemptions for packaging for elderly patients.

b. The manufacturer shall label packaged medical cannabidiol as described in subrule 154.21(3).

- c. The manufacturer shall use medical containers that are:
 - (1) Of sufficient size to accommodate a separate dispensary label containing the information described in rule 641—154.46(124E);
 - (2) Designed to maximize the shelf life of the contained medical cannabidiol;
 - (3) Tamper-evident; and
 - (4) Child-resistant.
- d. Medical cannabidiol packaging shall not bear a reasonable resemblance to commonly available nonmedical commercial products.
- e. The manufacturer shall package medical cannabidiol in a manner that minimizes the package's appeal to children.
- f. The manufacturer shall not depict images other than the manufacturer's business name or logo on the packaging.

154.21(2) Trade names. A manufacturer's medical cannabidiol trade names shall comply with the following:

- a. Names shall be limited to those that clearly reflect the form's medical cannabidiol nature;
- b. Any name that is identical to, or similar to, the name of an existing nonmedical cannabidiol product is prohibited;
- c. Any name that is identical to, or similar to, the name of an unlawful product or substance is prohibited; and
- d. Any name that contains language that suggests using medical cannabidiol for recreational purposes or for a condition other than a qualifying debilitating medical condition is prohibited.

154.21(3) Package labeling.

a. A manufacturer shall ensure that all medical cannabidiol packaging is labeled with the following information:

- (1) The name of the manufacturer;
- (2) The medical cannabidiol's primary active ingredients, including concentrations of tetrahydrocannabinol, tetrahydrocannabinolic acid, cannabidiol, and cannabidiolic acid. Concentrations of tetrahydrocannabinolic acid and cannabidiolic acid may be omitted if the manufacturer uses chemical decarboxylation or other means to substantially remove the acids from the product prior to testing;
- (3) All ingredients of the product shown with common or usual names, including any colors, artificial flavors, and preservatives, listed in descending order by predominance of weight;
- (4) Instructions for storage, including light and temperature requirements, if any;
- (5) Product expiration date;
- (6) The date of manufacture and lot number;
- (7) A notice with the statement, including capitalization: "This product has not been analyzed or approved by the United States Food and Drug Administration. There is limited information on the side effects of using this product, and there may be associated health risks and medication interactions. This product is not recommended for use by pregnant or breastfeeding women. KEEP THIS PRODUCT OUT OF REACH OF CHILDREN.";
- (8) The universal warning symbol provided by the department; and
- (9) A notice with the statement: "This medical cannabidiol is for therapeutic use only. Use of this product by a person other than the patient listed on the label is unlawful and may result in the cancellation of the patient's medical cannabidiol registration card. Return unused medical cannabidiol to a dispensary for disposal."

b. Labeling text shall not include any false or misleading statements.

c. A package may contain multiple labels if the information required by this rule is not obstructed.

d. A manufacturer shall ensure that directions for use of the product, including recommended and maximum amount by age and weight, if applicable, are included with the product.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.22(124E) Transportation of medical cannabidiol and plant material.

154.22(1) *Transport of medical cannabidiol.* A manufacturer is authorized to transport medical cannabidiol to and from:

- a. Dispensaries;
- b. A laboratory for testing;
- c. A waste facility for disposal;
- d. Other sites only with departmental approval.

154.22(2) *Transport of plant material.* A manufacturer is authorized to transport cannabis plant material from its manufacturing facility to:

- a. A waste disposal site;
- b. Other sites only with departmental approval.

154.22(3) *Chain-of-custody tracking system.*

a. A manufacturer shall use the secure sales and inventory tracking system, if available, or a department-approved manifest system to track shipping of medical cannabidiol. The system shall include a chain of custody that records:

- (1) The name and address of the destination;
- (2) The weight and description of each individual package that is part of the shipment, and the total number of individual packages;
- (3) The date and time the medical cannabidiol shipment is placed into the transport vehicle;
- (4) The date and time the shipment is accepted at the delivery destination;
- (5) The person's identity, and the circumstances, duration, and disposition of any other person who had custody or control of the shipment; and
- (6) Any handling or storage instructions.

b. Before transporting medical cannabidiol, a manufacturer shall:

- (1) Record in the secure sales and inventory tracking system or on the manifest information about the material to be transported; and
- (2) Notify the dispensary, laboratory, or waste facility, as applicable, of the expected arrival time and transmit a copy of the manifest to the dispensary, laboratory, or waste facility, if applicable.

c. Each transport shall be approved electronically or in writing by:

- (1) An authorized manufacturer employee when the transport vehicle is departing the manufacturing facility; and
- (2) An authorized employee of the receiving dispensary, laboratory, or waste facility.

d. An authorized employee at the dispensary, laboratory, or waste facility receiving medical cannabidiol shall:

- (1) Verify and document the type and quantity of the transported medical cannabidiol against the information in the secure sales and inventory tracking system or written manifest;
- (2) Approve the transport electronically or return a signed copy of the manifest to the manufacturing facility; and
- (3) Record the medical cannabidiol that is received as inventory in the secure sales and inventory tracking system, if available. If a manifest system is being used, the dispensary, laboratory, or waste facility shall also maintain a signed copy of manifest, and shall maintain records of the inventory received consistent with these rules.

e. A manufacturer shall maintain all manifests for at least five years and make them available upon request of the department.

154.22(4) *Vehicle requirements for transport.*

a. A manufacturer shall ensure that all medical cannabidiol transported on public roadways is:

- (1) Packaged in tamper-evident, bulk containers;
- (2) Transported so it is not visible or recognizable from outside the vehicle; and
- (3) Transported in a vehicle that does not bear any markings to indicate that the vehicle contains medical cannabidiol or bears the name or logo of the manufacturer.

b. When the motor vehicle contains medical cannabidiol, manufacturer employees who are transporting the medical cannabidiol on public roadways shall:

- (1) Travel directly to a dispensary or other department-approved locations; and

- (2) Document refueling and all other stops in transit, including:
 1. The reason for the stop;
 2. The duration of the stop; and
 3. The location of the stop.
- c. If the vehicle must be stopped due to an emergency situation, the employee shall notify 911 and complete an incident report on a form approved by the department.
- d. Under no circumstance shall any person other than a designated manufacturer employee have actual physical control of the motor vehicle that is transporting the medical cannabidiol.
- e. A single employee may transport medical cannabidiol to the laboratory.
- f. An employee in a transport motor vehicle shall have telephone or other communication access with the manufacturer's personnel and have the ability to contact law enforcement via telephone or other method at all times that the motor vehicle contains medical cannabidiol.
- g. An employee shall carry the employee's identification card at all times when transporting or delivering medical cannabidiol and, upon request, produce the identification card to the department or to a law enforcement officer acting in the course of official duties.
- h. A manufacturer shall not leave a vehicle that is transporting medical cannabidiol unattended overnight.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4928C, IAB 2/12/20, effective 6/1/20; see correction note at end of chapter]

641—154.23(124E) Disposal of medical cannabidiol and plant material.

154.23(1) *Return of medical cannabidiol from dispensaries and laboratory.*

a. A manufacturer shall collect at no charge medical cannabidiol waste from dispensaries. A manufacturer shall:

- (1) Collect medical cannabidiol waste from each dispensary on a schedule mutually agreed upon by the manufacturer and dispensary;
- (2) Dispose of medical cannabidiol waste as provided in subrule 154.23(2); and
- (3) Maintain a written record of disposal that includes:
 1. The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable, when the medical cannabidiol was returned to the dispensary from a patient or primary caregiver;
 2. The date the medical cannabidiol waste was collected;
 3. The quantity of medical cannabidiol waste collected; and
 4. The type and lot number of medical cannabidiol waste collected.

b. A manufacturer shall collect at no charge medical cannabidiol and medical cannabidiol waste from a laboratory that has tested samples submitted by the manufacturer. A manufacturer shall:

- (1) Collect medical cannabidiol and medical cannabidiol waste from a laboratory on a schedule mutually agreed upon by the manufacturer and laboratory.
- (2) Maintain a written record of return that includes:
 1. The date the medical cannabidiol and medical cannabidiol waste were collected;
 2. The quantity of medical cannabidiol and medical cannabidiol waste collected; and
 3. The type and lot number of medical cannabidiol collected.
- (3) A manufacturer may use medical cannabidiol returned from a laboratory for research and development or retained samples, but a manufacturer shall not introduce medical cannabidiol returned from a laboratory into lots or products intended for sale.
- (4) A manufacturer shall dispose of medical cannabidiol waste returned from a laboratory as provided in subrule 154.23(2).

154.23(2) *Medical cannabidiol and plant material waste.* A manufacturer shall store, secure, and manage medical cannabidiol waste and plant material waste in accordance with all applicable federal, state, and local regulations.

a. The manufacturer shall dispose of medical cannabidiol waste at a waste facility according to federal and state law and in a manner which renders it unusable.

b. The manufacturer shall dispose of plant material waste at an approved solid waste disposal facility, according to federal and state law.

c. Before transport of plant material waste, the manufacturer shall render the plant material waste unusable and unrecognizable by grinding and incorporating the waste with a greater quantity of nonconsumable, solid wastes including:

- (1) Paper waste;
- (2) Cardboard waste;
- (3) Food waste;
- (4) Yard waste;
- (5) Vegetative wastes generated from industrial or manufacturing processes that prepare food for human consumption;
- (6) Soil; or
- (7) Other waste approved by the department.

154.23(3) *Liquid and chemical waste disposal.* A manufacturer shall dispose of all liquid and chemical product waste generated in the process of cultivating, manufacturing, and distributing medical cannabidiol in accordance with all applicable federal, state, and local regulations.

154.23(4) *Waste-tracking requirements.* A manufacturer shall use forms approved by the department to maintain accurate and comprehensive records regarding waste material. The records shall account for, reconcile, and evidence all waste activity related to the disposal of medical cannabidiol waste and plant material waste.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter; ARC 4928C, IAB 2/12/20, effective 6/1/20; see correction note at end of chapter]

641—154.24(124E) Record-keeping requirements.

154.24(1) *Sales and distribution.* A manufacturer shall maintain complete and accurate electronic sales transaction records in the department's secure sales and inventory tracking system, including:

- a. The date of each sale or distribution;
- b. The item number, product name and description, and quantity of medical cannabidiol sold or otherwise distributed; and
- c. The sale price.

154.24(2) *Financial transactions.* A manufacturer shall maintain records that reflect all financial transactions and the financial condition of the business. The following records shall be maintained for at least five years and made available for review, upon request of the department:

- a. Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, to include the items or services purchased, from whom the items were purchased, and the date of purchase;
- b. Bank statements and canceled checks for all business accounts;
- c. Accounting and tax records;
- d. Records of all financial transactions, including contracts and agreements for services performed or services received;

154.24(3) *Other records.*

a. A manufacturer shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

- (1) All personnel records;
- (2) Records of any theft, loss, or other unaccountability of any medical cannabidiol or plant material;
- (3) Transport manifests and incident reports; and
- (4) Records of all samples sent to a testing laboratory and the quality assurance test results.

b. A manufacturer shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

c. A manufacturer shall use the department's secure sales and inventory tracking system to maintain the following:

- (1) Crop input records;
- (2) Production records;
- (3) Transportation records; and
- (4) Inventory records, including disposal of waste.

154.24(4) *Entry into the department's secure sales and inventory tracking system.* Unless otherwise provided in these rules, a manufacturer shall adhere to the following schedule for entering data into the department's secure sales and inventory tracking system.

- a. A manufacturer shall enter data in real time for data related to:
 - (1) Transport of plant material, waste material, and laboratory samples; and
 - (2) Sales of medical cannabidiol to dispensaries.
- b. A manufacturer shall enter data on changes to inventory of plant material, medical cannabidiol, and waste material by the end of the business day in which the changes occurred.
- c. A manufacturer shall enter data within five business days for data related to:
 - (1) Application and use of crop inputs and other solvents and chemicals; and
 - (2) Other manufacturing and production records not related to inventory of plant material, medical cannabidiol, and waste material.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.25(124E) Production requirements.

154.25(1) *Cultivation and processing.*

- a. Only a licensed manufacturer is authorized to produce and manufacture medical cannabidiol.
- b. All phases of production shall take place in designated, restricted access areas that are monitored by a surveillance camera system in accordance with rule 641—154.18(124E).
- c. The production process shall be designed to limit contamination. Examples of contamination include mold, fungus, bacterial diseases, rot, pests, nonorganic pesticides, and mildew.
- d. Each production area shall allow for access, observation, and inventory of each plant group.
- e. Biosecurity measures shall be in effect as described in the operating documents pursuant to subrule 154.17(1).

154.25(2) *Crop inputs and plant batches.*

- a. The manufacturer shall use the department's secure sales and inventory tracking system to maintain an electronic record of all crop inputs. The record shall include the following:
 - (1) The date of input application;
 - (2) The name of the employee applying the crop input;
 - (3) The crop input that was applied;
 - (4) The plants that received the application; and
 - (5) A copy of or electronic link to the safety data sheet for the crop input applied.
- b. At the time of harvesting, all plants shall be tracked in a batch process with a unique batch number that shall remain with the batch through final processing into medical cannabidiol.
- c. Each batch or part of a batch of cannabis plants that contributes to a lot of medical cannabidiol shall be recorded in the department's secure sales and inventory tracking system or other manifest system.

154.25(3) *Production of medical cannabidiol.*

- a. A manufacturer shall comply with all state and local building and fire code requirements.
- b. A manufacturer shall obtain approval from the department for use of any hydrocarbon-based extraction process. Examples of a hydrocarbon-based extraction process include the use of butane, ethanol, hexane, and isopropyl alcohol.
- c. Medical cannabidiol shall be prepared, handled, and stored in compliance with the sanitation requirements in this rule.
- d. A manufacturer shall produce shelf-stable, nonperishable forms of medical cannabidiol.
- e. A manufacturer shall ensure that the cannabinoid content of the medical cannabidiol it produces is homogenous.

f. Each lot of medical cannabidiol shall be assigned a unique lot number and recorded in the department's secure sales and inventory tracking system or other manifest system.

154.25(4) General sanitation requirements. A manufacturer shall take all reasonable measures and precautions to ensure that:

a. Any employee who has a communicable disease does not perform any tasks that might contaminate plant material or medical cannabidiol;

b. Hand-washing facilities are:

(1) Convenient and furnished with running water at a suitable temperature;

(2) Located in all production areas; and

(3) Equipped with effective hand-cleaning and -sanitizing preparations and sanitary towel service or electronic drying devices;

c. All employees working in direct contact with plant material and medical cannabidiol use hygienic practices while on duty, including:

(1) Maintaining personal cleanliness; and

(2) Washing hands thoroughly in a hand-washing area before starting work and at any other time when the hands may have become soiled or contaminated;

d. Litter and waste are routinely removed and the operating systems for waste disposal are routinely inspected;

e. Floors, walls, and ceilings are constructed with a surface that can be easily cleaned and maintained in good repair to inhibit microbial growth;

f. Lighting is adequate in all areas where plant material and medical cannabidiol are processed, stored, or sold;

g. Screening or other protection against the entry of pests is provided, including that rubbish is disposed of to minimize the development of odor and the potential for the waste becoming an attractant, harborage, or breeding place for pests;

h. Any buildings, fixtures, and other facilities are maintained in a sanitary condition;

i. Toxic cleaning compounds, sanitizing agents, and other potentially harmful chemicals are identified and stored in a separate location away from plant material and medical cannabidiol and in accordance with applicable local, state, or federal law;

j. All contact surfaces, utensils, and equipment used in the production of plant material and medical cannabidiol are maintained in a clean and sanitary condition;

k. The manufacturing facility water supply is sufficient for necessary operations;

l. Plumbing size and design meets operational needs and all applicable state and local laws;

m. Employees have accessible toilet facilities that are sanitary and in good repair; and

n. Plant material and medical cannabidiol that could support the rapid growth of undesirable microorganisms are isolated to prevent the growth of those microorganisms.

154.25(5) Storage.

a. A manufacturer shall store plant material and medical cannabidiol during production, transport, and testing to prevent diversion, theft, or loss, including ensuring that:

(1) Plant material and medical cannabidiol are returned to a secure location immediately after completion of the process or at the end of the scheduled business day; and

(2) The tanks, vessels, bins, or bulk containers containing plant material or medical cannabidiol are locked inside a secure area if a process is not completed at the end of a business day.

b. A manufacturer shall store all plant material and medical cannabidiol during production, transport, and testing, and all saleable medical cannabidiol:

(1) In areas that are maintained in a clean, orderly, and well-ventilated condition; and

(2) In storage areas that are free from infestation by insects, rodents, birds, and other pests of any kind.

c. To prevent degradation, a manufacturer shall store all plant material and medical cannabidiol in production, transport, and testing, and all saleable medical cannabidiol under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

d. A manufacturer shall maintain a separate secure storage area for medical cannabidiol that is returned from a dispensary, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the returned medical cannabidiol is destroyed. For purposes of this rule, a separate secure storage area includes a container, closet, or room that can be locked or secured.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter; ARC 4928C, IAB 2/12/20, effective 6/1/20; see correction note at end of chapter]

641—154.26(124E) Quality assurance and control.

154.26(1) *Quality control program.* A manufacturer shall develop and implement a written quality assurance program that assesses the chemical and microbiological composition of medical cannabidiol. Assessment includes a profile of the active ingredients, including shelf life, and the presence of inactive ingredients and contaminants. A manufacturer shall use these testing results to determine appropriate storage conditions and product expiration dates.

154.26(2) *Sampling protocols.* A manufacturer shall develop and follow written procedures for sampling medical cannabidiol that require the manufacturer to:

- a.* Conduct sample collection in a manner that provides analytically sound and representative samples;
- b.* Document every sampling event and provide this documentation to the department upon request;
- c.* Describe all sampling and testing plans in written procedures that include the sampling method and the number of units per lot to be tested;
- d.* Ensure that random samples from each lot are:
 - (1) Taken in an amount necessary to conduct the applicable test;
 - (2) Labeled with the lot number; and
 - (3) Submitted for testing;
- e.* Retain the results from the random samples for at least five years; and
- f.* Notify the department at least two business days prior to sample collection and allow the department or its designees to be present to observe the sampling procedures when the samples are to be sent to a laboratory for testing.

154.26(3) *Sampling and testing.* A manufacturer shall:

- a.* Work with the department and laboratory personnel to develop acceptance criteria for all potential contaminants based on the levels of metals, microbes, or other contaminants that the manufacturer uses in cultivating and producing medical cannabidiol;
- b.* Conduct sampling and testing of plant material and medical cannabidiol lots using acceptance criteria that are protective of patient health. The sampling and testing results shall be approved by the department and laboratory personnel and shall ensure that lots of medical cannabidiol meet allowable health risk limits for contaminants. Testing of plant material and lots shall occur as described in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).
- c.* Refrain from packaging or selling medical cannabidiol from a process lot that fails to meet established standards, specifications, and any other relevant quality control criteria. Medical cannabidiol from a process lot that fails quality assurance testing may be remixed and retested;
- d.* Reject and destroy medical cannabidiol from a lot that fails to meet established standards, specifications, and any other relevant quality control criteria when remixing and retesting are not warranted;
- e.* Develop and follow a written procedure for responding to results failing to meet established standards, specifications, and any other relevant quality control criteria, including:
 - (1) Criteria for when remixing and retesting are warranted;
 - (2) Instructions for destroying contaminated or substandard medical cannabidiol as provided in subrule 154.23(2) when remixing and retesting are not warranted; and
 - (3) Instructions for determining the source of contamination;

f. Retain documentation of test results, assessment, and destruction of medical cannabidiol for at least five years.

154.26(4) Stability testing.

a. The quality assurance program shall include procedures for performing stability testing of each product type produced to determine product expiration dates. The procedures shall describe:

(1) Sample size and test intervals based on statistical criteria and departmental guidance pursuant to subrule 154.69(1) for each attribute examined to ensure valid stability estimates;

(2) Storage conditions for samples retained for testing; and

(3) Reliable and specific test methods.

b. Stability studies shall include:

(1) Medical cannabidiol testing at appropriate intervals; and

(2) Medical cannabidiol testing in the same container-closure system in which the medical cannabidiol is marketed and dispensed.

c. If product-expiration-date studies have not been completed before December 1, 2018, a manufacturer shall assign a tentative product expiration date, not to exceed one year, based on any available stability information. A manufacturer shall concurrently conduct stability studies to determine the actual product expiration date.

d. After a manufacturer verifies the tentative product expiration date, or determines the appropriate product expiration date, a manufacturer shall include that product expiration date on each lot of medical cannabidiol.

e. Stability testing shall be repeated if the manufacturing process or the product's chemical composition is changed.

154.26(5) Reserve samples.

a. A manufacturer shall retain a uniquely labeled reserve sample that represents each lot of medical cannabidiol and store the reserve sample under conditions consistent with product labeling. The reserve sample shall be stored in the same immediate container-closure system in which the medical cannabidiol is marketed or in one that has similar characteristics. The reserve sample shall consist of at least twice the quantity necessary to perform all the required tests.

b. A manufacturer shall retain the reserve for at least two years from the date of manufacture.

c. After two years from the date of manufacture, reserve samples shall be destroyed as provided in subrule 154.23(2).

154.26(6) Retesting. If the department deems that public health may be at risk, the department may require the manufacturer to retest any sample of plant material or medical cannabidiol.

154.26(7) Disposal of substandard product. A manufacturer shall dispose of all medical cannabidiol as provided in subrule 154.23(2) when samples fail to meet established standards, specifications, and other relevant quality control criteria and when an adequate remedy for remixing and retesting as provided in paragraph 154.26(3) "c" is unavailable.

154.26(8) Recall and market withdrawal procedures. Each manufacturer shall establish a procedure for recalling or withdrawing from the market, as applicable, medical cannabidiol that has a reasonable probability of causing an unexpected or harmful response in a patient population, despite appropriate use, that outweighs the potential benefit of the medical cannabidiol. This procedure shall include:

a. Factors that make a recall or market withdrawal necessary;

b. Manufacturer's personnel who are responsible for overseeing the recall or market withdrawal; and

c. How to notify affected parties of a recall or market withdrawal.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.27(124E) Supply and inventory.

154.27(1) Reliable and ongoing supply. A manufacturer shall provide a reliable and ongoing supply of medical cannabidiol to medical cannabidiol dispensaries.

154.27(2) *Inventory controls and procedures.* A manufacturer shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.27(3) *Real-time inventory required.* A manufacturer shall use the department-approved secure sales and inventory tracking system to track medical cannabidiol production from seed or plant cutting through distribution of medical cannabidiol to a dispensary. The manufacturer shall use the system to maintain a real-time record of the manufacturer's inventory of plant material and medical cannabidiol to include:

- a. The quantity and form of medical cannabidiol maintained by the manufacturer at the manufacturing facility on a daily basis;
- b. The amount of plants being grown at the manufacturing facility on a daily basis;
- c. The names of the employees or employee conducting the inventory; and
- d. Other information deemed necessary and requested by the department.

154.27(4) *Waste inventory.* A manufacturer shall maintain a record of its inventory of all medical cannabidiol waste and plant material waste for disposal.

154.27(5) *Reconciliation.* No less often than every two calendar weeks, a manufacturer shall reconcile its physical inventory with the inventory recorded in the department's secure sales and inventory tracking system.

- a. Reconciliation shall include:
 - (1) Plant material at the manufacturing facility and in transit; and
 - (2) Medical cannabidiol at the manufacturing facility, at distribution and storage facilities, and in transit.

b. Discrepancies between the physical inventory of the manufacturer and the inventory recorded in the department's secure sales and inventory system shall be handled as follows:

- (1) A manufacturer shall report suspected diversion of plant material or medical cannabidiol to the department and law enforcement within 72 hours of discovery.
- (2) A manufacturer shall have up to 72 hours to reconcile discrepancies in the manufacturer's physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the manufacturer cannot reconcile the manufacturer's physical inventory with the secure sales and inventory tracking system's inventory within 72 hours but diversion of plant material or medical cannabidiol is not suspected, the manufacturer shall immediately contact the department to report the discrepancy and to initiate a compliance action plan pursuant to paragraph 154.28(4) "b."

154.27(6) *Scales.* All scales used to weigh usable plant material for purposes of these rules shall be certified in accordance with ISO/IEC Standard 17025, which is incorporated herein by reference.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.28(124E) *Inspection by department or independent consultant.* A manufacturer is subject to reasonable inspection by the department, a department-approved consultant, or other agency pursuant to Iowa Code chapter 124E and these rules and as authorized by laws and regulations.

154.28(1) *Types of inspections.* Inspections may include:

- a. Aspects of the business operations;
- b. The manufacturing facility;
- c. Vehicles used for transport or delivery of medical cannabidiol or plant material;
- d. Financial information and inventory documentation;
- e. Physical and electronic security alarm systems; and
- f. Other inspections as determined by the department.

154.28(2) *Local safety inspections.* A manufacturer may be subject to inspection of its manufacturing facility and grounds by the local fire department, building inspector, or code enforcement officer to confirm that no health or safety concerns are present. The inspection could result in additional specific standards to meet local licensing authority restrictions related to medical cannabidiol manufacturing or other local businesses. An annual fire safety inspection may result in the required installation of fire suppression devices, or other means necessary for adequate fire safety.

154.28(3) Health and sanitary inspection. The department has discretion to determine when an inspection by an independent consultant is necessary. The following is a nonexhaustive list of examples that may justify an independent inspection:

a. The department has reasonable grounds to believe that the manufacturer is in violation of one or more of the requirements set forth in these rules or other applicable public health or sanitary laws, rules or regulations; or

b. The department has reasonable grounds to believe that the manufacturer was the cause or source of contamination of medical cannabidiol.

154.28(4) Compliance required. A manufacturer shall respond to deficiencies found during inspections or inventory reconciliation as follows:

a. Deficiencies not related to inventory reconciliation.

(1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a manufacturer shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two weeks to accept or require revision of the action plan.

b. Deficiencies related to inventory reconciliation.

(1) Upon notifying the department that the manufacturer cannot reconcile the manufacturer's physical inventory with the inventory recorded in the department's secure sales and inventory tracking system, the manufacturer shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two business days to accept or require revision of the action plan.

c. Failure to complete actions in the action plan within the timelines mutually agreed upon by the manufacturer and the department shall result in assessment of penalties or in suspension or revocation of a manufacturer license as authorized by these rules.

d. At the department's request and in a timely manner, a manufacturer shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.29(124E) Assessment of penalties. The department shall assess to a manufacturer a civil penalty of up to \$1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.30(124E) Suspension or revocation of a manufacturer license.

154.30(1) The department may suspend or revoke a manufacturer license upon any of the following grounds:

a. Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.

b. Failure to submit required reports and documents.

c. Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.

d. Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.

e. Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.

f. False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.

g. Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.

h. Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.

i. Failure to correct a deficiency within the time frame required by the department.

j. Failure of a manufacturer's business owner or investors to have a satisfactory result in a background investigation or national criminal history background check conducted by the department of public safety and as determined by the department.

154.30(2) The department shall notify the licensee of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.30(3) A request for appeal concerning the suspension or revocation of a license shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice. The address is: Iowa Department of Public Health, Office of Medical Cannabidiol, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the suspension or revocation has been or will be removed. After the hearing or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the suspension or revocation. If no request for appeal is received within the 20-day time period, the department's notice of suspension or revocation shall become the department's final agency action.

154.30(4) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

154.30(5) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

154.30(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

154.30(7) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

154.30(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a.* All pleadings, motions, and rules.
- b.* All evidence received or considered and all other submissions by recording or transcript.
- c.* A statement of all matters officially noticed.
- d.* All questions and offers of proof, objections, and rulings thereon.
- e.* All proposed findings and exceptions.
- f.* The proposed decision and order of the administrative law judge.

154.30(9) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

154.30(10) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

154.30(11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.30(12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

154.30(13) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18A to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

(3) Whether the licensee required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.

(1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

(2) The written emergency adjudicative order shall be immediately delivered to the licensee that is required to comply with the order. The order shall be delivered by one or more of the following methods:

1. Personal delivery.

2. Certified mail, return receipt requested, to the last address on file with the department.

3. Fax. Fax may be used as the sole method of delivery if the licensee required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

(3) To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

(4) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the licensee that is required to comply with the order.

(5) After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

(6) Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the licensee that is required to comply with the order is the party requesting the continuance.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.31(124E) Closure of operations.

154.31(1) Notice. A manufacturer shall notify the department at least six months before the closure of the manufacturing facility.

154.31(2) Procedures. If a manufacturer ceases operation, the manufacturer shall work with the department to verify the remaining inventory of the manufacturer and ensure that any plant material, plant material waste, and medical cannabidiol are destroyed at a waste facility as provided in subrule 154.23(2).

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.32 to 154.39 Reserved.

DISPENSING

641—154.40(124E) Duties of the department.

154.40(1) *Interagency agreements.* The department may enter into any interagency agreements with other state agencies for technical services or other assistance related to the regulation or inspection of dispensaries.

154.40(2) *Notice to law enforcement.* The department shall notify local law enforcement agencies and the department of public safety of the locations of dispensaries. If the department has sufficient cause to believe that there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety of any conditions that pose a threat to public safety including but not limited to:

- a. Loss or theft of medical cannabidiol;
- b. Diversion or potential diversion of medical cannabidiol;
- c. Unauthorized access to the secure sales and inventory tracking system or other patient and caregiver information system or file; or
- d. Other violations of law.

154.40(3) *Inspection of dispensaries.* The department or its agents shall conduct regular inspections of dispensaries and their facilities as described in rule 641—154.52(124E).

154.40(4) *Establishment and maintenance of a secure sales and inventory tracking system.* The department shall establish and maintain a secure, electronic system that is available 24 hours a day, seven days a week to track:

- a. Inventory of medical cannabidiol and waste material;
- b. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

154.40(5) *Licensure and licensure renewal of dispensaries.* The department shall issue a request for proposals to select and license by April 1, 2018, up to five dispensaries to dispense medical cannabidiol within the state consistent with the provisions of Iowa Code chapter 124E and these rules.

a. To be eligible for licensure, an applicant dispensary shall provide information on forms and in a manner required by the department of public safety for the completion of a background investigation. In addition, the applicant dispensary shall submit to the department of public safety necessary funds to satisfy the full reimbursement of costs associated with completing the background investigations. If the applicant dispensary is not found suitable for licensure as a result of the background investigation, a license shall not be issued by the department.

b. As a condition for licensure, an applicant dispensary shall agree to begin dispensing medical cannabidiol to patients and primary caregivers in Iowa no later than December 1, 2018.

c. The initial license to dispense medical cannabidiol shall be valid from April 1, 2018, through November 30, 2018. The license shall be renewed annually unless a dispensary relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.

d. A license to dispense medical cannabidiol issued by the department pursuant to these rules is not assignable or transferable.

e. The department shall consider the following factors in determining whether to select and license a medical cannabidiol dispensary:

- (1) Geographical location of the proposed dispensary facility;
- (2) The technical expertise of an applicant dispensary's staff regarding medical cannabidiol;
- (3) The qualifications of an applicant dispensary's employees;
- (4) The long-term financial stability of an applicant dispensary;
- (5) The ability of an applicant dispensary to provide appropriate security measures on the premises of the dispensary;
- (6) An applicant dispensary's projection of and ongoing assessment of retail product costs, including any dispensing fees.

f. Pursuant to Iowa Code section 124E.8(1) “*b*,” information submitted during the application process shall be confidential until an applicant dispensary is licensed by the department unless otherwise protected from disclosure under state or federal law.

g. A licensed dispensary shall submit an application to renew its license with the department at least six months before the license expires. The application shall be submitted on a form created by the department.

h. The department shall notify a dispensary of the decision to approve or deny the dispensary’s license by August 1 of the year in which the renewal application is submitted.

154.40(6) *Collection of fees from dispensaries.* Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.

a. Fees to the department.

(1) One application is required for each dispensary location.

(2) Each application for licensure as a dispensary shall include a nonrefundable application fee of \$5,000.

(3) Licensed dispensaries shall pay an annual fee to the department to cover costs associated with regulating and inspecting dispensaries and for other expenses necessary for the administration of the medical cannabidiol program. The department shall assess the fee with the notice of approval of license renewal each year on August 1, payable by the dispensary to the department no later than December 1.

b. Fees to the department of public safety.

(1) An applicant dispensary shall be responsible to reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure and operation as a licensed dispensary. The department of public safety shall retain the right to bill a dispensary for additional background investigations, as needed.

(2) Each dispensary submitting an application for licensure shall, at time of application, submit to the department of public safety a deposit of \$10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the dispensary.

(3) A licensed dispensary shall pay a deposit of \$200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the dispensary. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the dispensary shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the dispensary. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

154.40(7) *Recall of medical cannabidiol products.* If the department determines, based on an evaluation of the health hazard presented, that there is a reasonable probability that use of, or exposure to, a violative medical cannabidiol product will cause a serious adverse health consequence or death, the department may require a dispensary to recall such violative medical cannabidiol products from the dispensary facility and from patients. An evaluation of the health hazard presented by medical cannabidiol being considered for recall shall be conducted by an ad hoc committee of scientists appointed by the director of the department and shall take into account, but need not be limited to, each of the following factors:

a. Whether any disease or injuries have already occurred from the use of the medical cannabidiol.

b. Whether any existing conditions could contribute to a clinical situation that could expose humans to a health hazard. Any conclusion shall be supported as completely as possible by scientific

documentation and/or statements that the conclusion is the opinion of the individual(s) making the health hazard determination.

c. Assessment of hazard to various segments of the population, e.g., children, who are expected to be exposed to the product being considered, with particular attention paid to the hazard to those individuals who may be at greatest risk.

d. Assessment of the degree of seriousness of the health hazard to which the populations at risk would be exposed.

e. Assessment of the likelihood of occurrence of the hazard.

f. Assessment of the consequences (immediate or long-range) of occurrence of the hazard.

g. The findings of the department during a directed inspection of the licensed manufacturing facility.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter; ARC 4928C, IAB 2/12/20, effective 6/1/20; see correction note at end of chapter]

641—154.41(124E) Dispensary operations.

154.41(1) *Operating documents.* The operating documents of a dispensary shall include all of the following:

a. Procedures for the oversight of the dispensary, including descriptions of operational and management practices regarding:

(1) The forms and quantities of medical cannabidiol products that will be stored and dispensed at the dispensary;

(2) The estimated forms and quantities of medical cannabidiol waste to be generated or collected;

(3) The disposal methods for all waste materials;

(4) Employee training methods for the dispensary employees;

(5) Strategies for identifying and reconciling discrepancies in inventory of medical cannabidiol;

(6) Medical cannabidiol labeling procedures;

(7) Procedures for recall or market withdrawal of medical cannabidiol;

(8) Plans for responding to a security breach at the dispensary facility;

(9) A business continuity plan; and

(10) Other information requested by the department.

b. Procedures to ensure accurate record keeping.

c. Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas of the dispensary facility containing medical cannabidiol.

154.41(2) *Prohibited activities.*

a. A person or entity shall not own or operate a dispensary unless the person or entity is licensed by the department pursuant to Iowa Code chapter 124E and these rules.

b. A dispensary shall not:

(1) Dispense medical cannabidiol in any location except in those areas approved by the department;

(2) Sell, receive, transport, or distribute medical cannabidiol from any location except its dispensary;

(3) Sell, receive, or distribute medical cannabidiol from any entity other than a manufacturer licensed by the department;

(4) Sell or distribute medical cannabidiol to any person other than an approved patient or primary caregiver;

(5) Transport or deliver medical cannabidiol to any location, unless approved by the department;

(6) Sell medical cannabidiol that is not packaged and labeled in accordance with rules 641—154.21(124E) and 641—154.46(124E);

(7) Repackage medical cannabidiol or remove the manufacturer's label;

(8) Sell medical cannabidiol in any form or quantity other than a form or quantity approved by the department and adopted by rule;

(9) Permit any person to consume medical cannabidiol on the property of the dispensary;

(10) Employ a person who is under 18 years of age or who has been convicted of a disqualifying felony offense.

154.41(3) Criminal background checks.

a. An owner of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

b. An employee of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

c. An applicant or licensed dispensary shall respond within 30 days to a request from the department or the department of public safety for more information to complete a background investigation and national criminal history background check on an owner, investor, or employee.

154.41(4) Relationship to health care practitioners. A dispensary shall not share office space with, refer patients to, or have any financial relationship with a health care practitioner.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.42(124E) Security requirements. The department may request assistance from the department of public safety in ensuring dispensaries meet the security requirements in this rule.

154.42(1) Restricted access. A dispensary shall have a controlled access system to limit entrance to all restricted access areas of the dispensary facility. Visitors to restricted access areas shall sign manifests with name, date, and times of entry and exit, if the controlled access system cannot electronically record visitors. Visitors shall wear badges that are visible at all times and identify them as visitors.

a. The controlled access system shall do all of the following:

(1) Limit access to authorized individuals;

(2) Maintain a log of individuals with approved access, including dates of approvals and revocations;

(3) Track times of personnel entry to and exit from restricted access areas;

(4) Store data for retrieval for a minimum of one year; and

(5) Limit access to authorized individuals in the event of a power failure.

b. A dispensary shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

c. Separate written manifests of visitors to restricted access areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted access areas.

d. Restricted access areas shall be identified with signs that state: “Do Not Enter – Restricted Access Area – Access Limited to Authorized Personnel Only.”

154.42(2) Perimeter intrusion detection system.

a. *Computer-controlled video surveillance system.* A dispensary shall operate and maintain in good working order a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days a week, and visually records:

(1) All areas that might contain medical cannabidiol, including all safes, vaults, and storage areas;

(2) All points of entry and exit;

(3) The entrance to the video surveillance control room; and

(4) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. *Camera specifications.* Cameras shall:

(1) Capture clear and certain identification of any person entering or exiting a dispensary or its parking areas to the extent identification is technologically feasible with generally accepted commercial security cameras;

(2) Have the ability to produce a clear, color still photograph live or from a recording;

(3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and

(4) Continue to operate during a power outage.

c. Video recording specifications.

(1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.

(2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.

(3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.

(4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A dispensary shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A dispensary shall ensure that recordings from all video cameras are:

(1) Available for viewing by the department upon request;

(2) Retained for at least 60 days;

(3) Maintained free of alteration or corruption; and

(4) Retained longer, as needed, if a dispensary is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

f. Required signage. A dispensary shall post a sign in capital letters in a conspicuous location at every entrance to the dispensary that reads, "THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE."

154.42(3) Security alarm system requirements.

a. A dispensary shall install and maintain a professionally monitored security alarm system that provides intrusion and fire detection of all:

(1) Dispensary entrances and exits;

(2) Rooms with exterior windows;

(3) Rooms with exterior walls;

(4) Roof hatches;

(5) Skylights; and

(6) Storage rooms.

b. For the purposes of this subrule, a security alarm system means a device or series of devices that summons law enforcement personnel during, or as a result of, an alarm condition. Devices may include:

(1) Hardwired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audio, visual, or electronic signal;

(2) Motion detectors;

(3) Pressure switches;

(4) A duress alarm;

(5) A panic alarm;

(6) A holdup alarm;

(7) An automatic voice dialer; and

(8) A failure notification system that provides an audio, text, or visual notification of any failure in the surveillance system.

c. A dispensary's security alarm system and all devices shall continue to operate during a power outage.

d. A dispensary's security alarm system shall be inspected and all devices tested annually by a qualified alarm vendor. A dispensary shall provide documentation of the annual inspection and device testing to the department upon request.

154.42(4) Personnel identification system. A dispensary shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the dispensary and that meets the requirements of this subrule and subrule 154.42(1).

a. Requirement for employee identification card. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance and expiration;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A dispensary's employees shall keep the identification card visible at all times when the employee is in a dispensary or a vehicle transporting medical cannabidiol.

c. Upon termination or resignation of an employee, a dispensary shall immediately:

- (1) Revoke the employee's access to restricted access areas of the dispensary; and
- (2) Obtain and destroy the employee's identification card, if possible.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.43(124E) Location. All dispensing of medical cannabidiol shall take place in an enclosed facility at one physical address provided to the department during the licensure process.

154.43(1) Proximity to manufacturers. A dispensary shall not operate at the same physical location as a manufacturer.

154.43(2) Proximity to schools. A dispensary shall not operate in any location within 1,000 feet of a public or private school existing before the date of the dispensary's licensure by the department.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.44(124E) Advertising and marketing.

154.44(1) Permitted marketing and advertising activities.

a. A dispensary may:

(1) Display the dispensary's business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:

1. Images of cannabis or cannabis-use paraphernalia;
2. Colloquial references to cannabis;
3. Names of cannabis plant strains or varieties;
4. Unsubstantiated medical claims; or
5. Medical symbols that bear a reasonable resemblance to established medical associations.

Examples of established medical organizations include the American Medical Association or American Academy of Pediatrics. The use of medical symbols is subject to approval by the department.

(2) Display signs on the dispensary; and

(3) Maintain a business website that contains the following information:

1. The dispensary's name and contact information;
2. The medical cannabidiol forms and quantities provided;
3. Medical cannabidiol pricing;
4. Hours of operation; and
5. Other information as approved by the department.

b. The business website shall not include any false, misleading, or unsubstantiated statements.

c. The department reserves the right to review a dispensary's marketing and advertising materials and to require a dispensary to make changes to the content. The department has 30 calendar days following submission to approve or deny marketing and advertising materials of a dispensary.

154.44(2) Other marketing and advertising activities. A dispensary shall request and receive the department's written approval before beginning marketing or advertising activities that are not specified in subrule 154.44(1). The department has 30 calendar days to approve, deny, or request additional information regarding marketing and advertising activity requests from a dispensary. In the event the department fails to respond to a dispensary within 30 days with an approval, denial, or request for additional information, the dispensary's marketing and advertising activity requests shall be deemed approved.

154.44(3) Inconspicuous display. A dispensary shall arrange displays of medical cannabidiol, interior signs, and other exhibits to reasonably prevent public viewing from outside the dispensary.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.45(124E) Storage.**154.45(1) Storage of saleable medical cannabidiol.**

a. A dispensary shall store medical cannabidiol to prevent diversion, theft, or loss, including ensuring that:

- (1) Medical cannabidiol is kept in a secure and monitored location within the dispensary; and
- (2) Cabinets or storage containers inside the secure and monitored area are locked at the end of a business day.

b. A dispensary shall store all medical cannabidiol:

- (1) In areas that are maintained in a clean, orderly, and well-ventilated condition;
- (2) In areas that are free from infestation by insects, rodents, birds, and other pests of any kind;
- (3) According to the manufacturer's requirements regarding temperature, light exposure, or other environmental conditions;
- (4) Under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

154.45(2) Storage of returned medical cannabidiol. A dispensary shall maintain a separate secure storage area for medical cannabidiol that is to be returned to a manufacturer for disposal, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the medical cannabidiol is collected by a manufacturer. For purposes of this subrule, a separate secure storage area includes a container, closet, or room that can be locked or secured.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.46(124E) Dispensing.

154.46(1) Access to all forms of product. A dispensary shall provide access to all medical cannabidiol forms produced by each licensed manufacturer.

154.46(2) Dispensing to a patient.

a. Prior to dispensing any medical cannabidiol to a patient, a dispensary shall do all of the following:

- (1) Verify the patient's identity;
- (2) Verify that the patient is registered and listed in the secure sales and inventory tracking system and has a valid medical registration card;
- (3) Assign a tracking number to any medical cannabidiol that is to be dispensed to the patient;
- (4) Issue a label that contains the following information:
 1. The medical cannabidiol tracking number; and
 2. The patient registration number;
- (5) Ensure the following information, which may be printed on a secondary label or package insert, is issued with dispensed medical cannabidiol:
 1. The date and time the medical cannabidiol is dispensed;
 2. The name and address of the dispensary;
 3. Any specific instructions for use based upon manufacturer guidelines or department rules.

Text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

b. The dispensary shall record the patient name, the amount dispensed, the price, the medical cannabidiol tracking number, the time and date, and other information required by the department in the secure sales and inventory tracking system within one business day.

154.46(3) Dispensing to a primary caregiver.

a. Prior to dispensing any medical cannabidiol to a primary caregiver, a dispensary shall do all of the following:

- (1) Verify the primary caregiver's identity;
- (2) Verify that the patient and the primary caregiver are registered and listed in the secure sales and inventory tracking system and have valid medical registration cards;

(3) Assign a medical cannabidiol tracking number to any medical cannabidiol that is to be dispensed to the primary caregiver;

(4) Issue a label that contains the following information:

1. The medical cannabidiol tracking number; and
2. The patient registration number;

(5) Ensure the following information, which may be printed on a secondary label or package insert, is issued with dispensed medical cannabidiol:

1. The date and time the medical cannabidiol is dispensed;
2. The name and address of the dispensary;
3. Any specific instructions for use based upon manufacturer guidelines or department rules.

Text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

b. The dispensary shall record the names of the patient and primary caregiver, the amount dispensed, the price, the medical cannabidiol tracking number, the time and date, and other information required by the department in the secure sales and inventory tracking system within one business day. [ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.47(124E) Transportation of medical cannabidiol. A dispensary is not authorized to transport medical cannabidiol, unless approved by the department. Any approved transport shall be logged in the secure sales and inventory tracking system. [ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.48(124E) Disposal of medical cannabidiol.

154.48(1) Identification of excess, expired, or damaged medical cannabidiol.

a. Dispensaries shall identify unused, excess, expired, or damaged medical cannabidiol for return to manufacturers.

b. Unused, excess, expired, or damaged medical cannabidiol shall be stored as described in subrule 154.45(2).

154.48(2) Return of medical cannabidiol from a patient or primary caregiver to a dispensary.

a. A dispensary shall accept at no charge medical cannabidiol waste from any patient or primary caregiver. A dispensary shall provide all medical cannabidiol waste to the manufacturer for disposal.

b. The dispensary shall enter the following information into the secure sales and inventory tracking system for all medical cannabidiol returned from a patient or primary caregiver:

(1) The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable, when the medical cannabidiol was returned to the dispensary from a patient or primary caregiver;

(2) The date the medical cannabidiol was returned;

(3) The quantity of medical cannabidiol returned; and

(4) The type and lot number of medical cannabidiol returned.

c. A dispensary shall store medical cannabidiol returned from patients and primary caregivers as described in subrule 154.45(2).

154.48(3) Return of medical cannabidiol to a manufacturer.

a. A manufacturer shall collect and dispose of medical cannabidiol from dispensaries as provided in rule 641—154.23(124E).

b. A dispensary shall record information on all medical cannabidiol collected by the manufacturer in the secure sales and inventory tracking system. Information shall include:

(1) The date the medical cannabidiol was collected by the manufacturer;

(2) The quantity of medical cannabidiol collected; and

(3) The type and lot number of medical cannabidiol collected.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.49(124E) Record-keeping requirements.

154.49(1) Sales. A dispensary shall maintain complete and accurate electronic sales transaction records in the department's secure sales and inventory tracking system, including:

- a. The name of the patient and, if purchase is made by the primary caregiver, the name of the primary caregiver;
- b. The date of each sale;
- c. The item number, product name and description, and quantity of medical cannabidiol sold;
- d. The sale price;
- e. Other information required by the department.

154.49(2) Financial transactions. A dispensary shall maintain records that reflect all financial transactions and the financial condition of the business. The following records shall be maintained for at least five years and made available for review, upon request of the department:

- a. Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, to include the items or services purchased, from whom the items were purchased, and the date of purchase;
- b. Bank statements and canceled checks for all business accounts;
- c. Accounting and tax records;
- d. Records of all financial transactions, including contracts and agreements for services performed or services received.

154.49(3) Other records.

a. A dispensary shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

- (1) All personnel records; and
- (2) Records of any theft, loss, or other unaccountability of any medical cannabidiol.

b. A dispensary shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

c. A dispensary shall use the department's secure sales and inventory tracking system to maintain the following:

- (1) Inventory records;
- (2) Return of medical cannabidiol from a patient or primary caregiver; and
- (3) Return of unused, excess, expired, or damaged medical cannabidiol to a manufacturer.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.50(124E) Quality assurance and control. A dispensary shall cooperate with manufacturers and the department on quality assurance and control procedures, including participating in stability-testing studies, developing sampling strategies, and returning medical cannabidiol that has been recalled or withdrawn from the market.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.51(124E) Inventory.

154.51(1) Inventory controls and procedures. A dispensary shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.51(2) Real-time inventory required. A dispensary shall use the department-approved secure sales and inventory tracking system to maintain a real-time record of the dispensary's inventory of medical cannabidiol to include:

- a. The quantity and form of saleable medical cannabidiol maintained at the dispensary on a daily basis;
- b. The amount of damaged, expired, or returned medical cannabidiol being held at the dispensary for return to a manufacturer; and
- c. Other information deemed necessary and requested by the department.

154.51(3) Reconciliation. At least once a calendar week, a dispensary shall reconcile all medical cannabidiol at the dispensary with the inventory recorded in the department's secure sales and inventory tracking system. Discrepancies shall be handled as follows:

a. A dispensary shall report suspected diversion of medical cannabidiol to the department and law enforcement within 24 hours of discovery.

b. A dispensary shall have up to 24 hours to reconcile the dispensary's physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the dispensary cannot reconcile the dispensary's physical inventory with the secure sales and inventory tracking system's inventory within 24 hours but diversion of product is not suspected, the dispensary shall immediately contact the department to report the discrepancy and to initiate a compliance action plan pursuant to paragraph 154.52(4) "b."

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.52(124E) Inspection by department or independent consultant. A dispensary is subject to reasonable inspection by the department, a department-approved consultant, or other agency as authorized by Iowa Code chapter 124E and these rules or state or local laws and regulations.

154.52(1) Types of inspections. Inspections may include:

- a.* Aspects of the business operations;
- b.* The physical location of a dispensary, including any storage facilities;
- c.* Financial information and inventory documentation;
- d.* Physical and electronic security alarm systems; and
- e.* Other aspects or areas as determined by the department.

154.52(2) Local safety inspections. A dispensary may be subject to inspection of its dispensary by the local fire department, building inspector, or code enforcement officer to confirm that no health or safety concerns are present. The inspection could result in additional specific standards to meet local licensing authority restrictions related to medical cannabidiol dispensing or other local businesses. An annual fire safety inspection may result in the required installation of fire suppression devices, or other means necessary for adequate fire safety.

154.52(3) Health and sanitary inspection. The department has discretion to determine when an inspection by an independent consultant is necessary. The following is a nonexhaustive list of examples that may justify an independent inspection:

- a.* The department has reasonable grounds to believe that the dispensary is in violation of one or more of the requirements set forth in these rules or other applicable public health or sanitary laws, rules or regulations;
- b.* The department has reasonable grounds to believe that the dispensary was the cause or source of contamination of medical cannabidiol; or
- c.* The department has reasonable grounds to believe that the dispensary was the cause of loss of product quality or change in chemical composition due to improper storage and handling of medical cannabidiol.

154.52(4) Compliance required. A dispensary shall respond to deficiencies found during inspections or inventory reconciliation as follows:

- a.* Deficiencies not related to inventory reconciliation.
 - (1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a dispensary shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.
 - (2) The department shall have up to two weeks to accept or require revision of the action plan.
- b.* Deficiencies related to inventory reconciliation.
 - (1) Upon notifying the department that the dispensary cannot reconcile the dispensary's physical inventory with the inventory recorded in the department's secure sales and inventory tracking system, the dispensary shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.
 - (2) The department shall have up to two business days to accept or require revision of the action plan.

c. Failure to complete actions in the action plan within the timelines mutually agreed upon by the dispensary and the department shall result in assessment of penalties or in suspension or revocation of a dispensary license as authorized by these rules.

d. At the department's request and in a timely manner, a dispensary shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 3606C, IAB 1/31/18, effective 3/7/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.53(124E) Assessment of penalties. The department shall assess to a dispensary a civil penalty of up to \$1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.54(124E) Suspension or revocation of a dispensary license.

154.54(1) The department may suspend or revoke a dispensary license upon any of the following grounds:

a. Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.

b. Failure to submit required reports and documents.

c. Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.

d. Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.

e. Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.

f. False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.

g. Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.

h. Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.

i. Failure to correct a deficiency within the time frame required by the department.

j. Failure of a dispensary's business owner to have a satisfactory result in a background investigation or national criminal history background check conducted by the department of public safety and as determined by the department.

154.54(2) The department shall notify the licensee of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.54(3) A request for appeal concerning the suspension or revocation of a license shall be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice. The address is: Iowa Department of Public Health, Office of Medical Cannabidiol, Lucas State Office Building, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the suspension or revocation has been or will be removed. After the hearing or upon default of the applicant or alleged violator, the administrative law judge shall affirm, modify or set aside the suspension or revocation. If no request for appeal is received within the 20-day time period, the department's notice of suspension or revocation shall become the department's final agency action.

154.54(4) Upon receipt of an appeal that meets contested case status, the appeal shall be forwarded within five working days to the department of inspections and appeals. The information upon which the adverse action is based and any additional information which may be provided by the aggrieved party shall also be provided to the department of inspections and appeals.

154.54(5) The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10.

154.54(6) When the administrative law judge makes a proposed decision and order, it shall be served by restricted certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

154.54(7) Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge's proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for an appeal shall state the reason for appeal.

154.54(8) Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing for submission to the director. The record shall include the following:

- a. All pleadings, motions, and rules.
- b. All evidence received or considered and all other submissions by recording or transcript.
- c. A statement of all matters officially noticed.
- d. All questions and offers of proof, objections, and rulings thereon.
- e. All proposed findings and exceptions.
- f. The proposed decision and order of the administrative law judge.

154.54(9) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

154.54(10) It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

154.54(11) Any petition for judicial review of a decision and order shall be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service. The address is: Iowa Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.54(12) The party who appeals a final agency action to the district court shall pay the cost of the preparation of a transcript of the contested case hearing for the district court.

154.54(13) Emergency adjudicative proceedings.

a. Necessary emergency action. To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18A to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

b. Before issuing an emergency adjudicative order, the department shall consider factors including, but not limited to, the following:

(1) Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;

(2) Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

(3) Whether the licensee required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

(4) Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

(5) Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

c. Issuance of order.

(1) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

(2) The written emergency adjudicative order shall be immediately delivered to the licensee that is required to comply with the order. The order shall be delivered by one or more of the following methods:

1. Personal delivery.
2. Certified mail, return receipt requested, to the last address on file with the department.
3. Fax. Fax may be used as the sole method of delivery if the licensee required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

(3) To the degree practicable, the department shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

(4) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the licensee that is required to comply with the order.

(5) After the issuance of an emergency adjudicative order, the department shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

(6) Issuance of a written emergency adjudicative order shall include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the licensee that is required to comply with the order is the party requesting the continuance.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.55(124E) Closure of operations.

154.55(1) Notice. A dispensary shall notify the department at least six months before the closure of the dispensary.

154.55(2) Procedures. If a dispensary ceases operation, the dispensary shall work with the department to verify the remaining inventory of the dispensary and ensure that any medical cannabidiol is returned to a manufacturer.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.56 to 154.59 Reserved.

MEDICAL CANNABIDIOL BOARD

641—154.60(124E) Purpose and duties of board.

154.60(1) The purpose of the board is to administer the provisions of Iowa Code section 124E.5.

154.60(2) Responsibilities of the board include but are not limited to:

a. Accepting and reviewing petitions to add medical conditions, medical treatments, or debilitating diseases to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial under Iowa Code chapter 124E.

b. Making recommendations to the board of medicine relating to the removal or addition of debilitating medical conditions to the list of allowable debilitating medical conditions for which the medical use of cannabidiol under Iowa Code chapter 124E would be medically beneficial.

c. Working with the department regarding the requirements for the licensure of manufacturers and dispensaries, including licensure procedures.

d. Advising the department regarding the location of manufacturers and dispensaries throughout the state.

e. Making recommendations to the board of medicine relating to the form and quantity of allowable medical uses of cannabidiol.

f. Considering recommendations to the general assembly for statutory revisions to the definition of medical cannabidiol to increase the tetrahydrocannabinol (THC) level to more than 3 percent.

g. Submitting an annual report to the general assembly detailing the activities of the board no later than January 1.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.61(124E) Organization of board and proceedings.

154.61(1) *Membership.* The board shall be composed of nine members appointed by the governor pursuant to Iowa Code section 124E.5. The appointments, unless provided otherwise by law, shall be for three-year staggered terms which shall expire on June 30. Board members shall be knowledgeable about the use of medical cannabidiol. The medical practitioners appointed to the board shall be licensed in Iowa and be nationally board-certified in their area of specialty.

154.61(2) *Vacancies.* Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

154.61(3) *Absences.* Three consecutive unexcused absences shall be grounds for the governor to consider dismissal of a board member and to appoint another. Department staff is charged with providing notification of absences to the governor's office.

154.61(4) *Board meetings.*

a. The board shall convene at least twice but no more than four times a year.

b. Board meetings shall be conducted in accordance with the open meetings requirements of Iowa Code chapter 21.

c. The department's office of medical cannabidiol shall schedule the time, date and location of meetings.

d. A majority of the members shall constitute a quorum for conducting business of the board.

e. An affirmative vote of a majority of the board members present at a meeting is required for a motion to pass.

154.61(5) *Facilities and staffing.* The department shall furnish the board with the necessary facilities and employees to perform the duties required by this chapter but shall be reimbursed for all costs incurred by fee revenue generated from licensing activities and registration card applications.

154.61(6) *Subcommittees.* The board may designate one or more subcommittees to perform such duties as may be deemed necessary.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.62(124E) Official communications. All official communications, including submissions, petitions and requests, may be addressed to the Medical Cannabidiol Board, Office of Medical Cannabidiol, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.63(124E) Office hours. The board office is open for public business from 8 a.m. to 4:30 p.m., Monday to Friday of each week, except holidays.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.64(124E) Public meetings. Members of the public may be present during board meetings unless the board votes to hold a closed session. Dates and location of board meetings may be obtained through the Iowa department of public health's website (idph.iowa.gov/mcarcp) or directly from the board office.

154.64(1) *Exclusion of participants.* The person presiding at a meeting of the board may exclude a person from an open meeting for behavior that obstructs the meeting.

154.64(2) *Recording of meetings.* Cameras and recording devices may be used at open meetings, provided the cameras or recording devices do not obstruct the meeting. If the user of a camera or recording device obstructs the meeting by the use of such device, the presiding department staff member at the meeting may request the user to discontinue use of the camera or device.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.65(124E) Petitions for the addition or removal of medical conditions, medical treatments or debilitating diseases. Petitions for the addition or removal of medical conditions, medical treatments,

or debilitating conditions for which the medical use of cannabidiol would be medically beneficial under Iowa Code chapter 124E may be submitted to the board pursuant to this rule.

154.65(1) *Petition form.* Any person or entity may file a petition to add or remove medical conditions, medical treatments or debilitating diseases with the board. A petition is deemed filed when it is received by the medical cannabidiol office. The board must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the board an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE MEDICAL CANNABIDIOL BOARD

Petition by (Name of Petitioner) for the (addition or removal) of (medical conditions, medical treatments or debilitating diseases) to the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.	}	PETITION FOR (ADDITION or REMOVAL)
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The petition must provide the following information:

- a. A statement of the specific medical condition, medical treatment or debilitating disease the petitioner is seeking to add to or remove from the list of debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial.
- b. A brief summary of the petitioner’s arguments in support of the action urged in the petition.
- c. A brief summary of any data or scientific evidence supporting the action urged in the petition.
- d. A list of reference material supporting the petition.
- e. A list of subject matter experts who are willing to testify in support of the petition. The list of subject matter experts must contain names, credentials (if applicable), email addresses, telephone numbers, and mailing addresses.
- f. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.

154.65(2) *Signature and address.* The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, telephone number and email address of the petitioner and petitioner’s representative, and a statement indicating the person to whom communications concerning the petition should be directed.

154.65(3) *Denial for format.* The board may deny a petition because it does not substantially conform to the required form.

154.65(4) *Briefs.* The petitioner may attach a brief to the petition in support of the action urged in the petition. The board may request a brief from the petitioner or from any other person or entity concerning the substance of the petition.

154.65(5) *Inquiries.* Inquiries concerning the status of a petition may be made to the Office of Medical Cannabidiol, Department of Public Health, Lucas State Office Building, Des Moines, Iowa 50319-0075.

154.65(6) *Additional information.* The board may request the petitioner to submit additional information concerning the petition. The board may also solicit comments from any person on the substance of the petition. Comments on the substance of the petition may be submitted to the board by any person.

154.65(7) *Presentation to the board.* The board may request or allow the petitioner to make an oral presentation of the contents of a petition at a board meeting following submission of the petition.

154.65(8) *Board response.* Within six months after the filing of the petition, or within any longer period agreed to by the petitioner, the board must, in writing, either deny the petition and notify the petitioner of the board’s action and the reasons therefore, or grant the petition and notify the petitioner that the board has recommended addition or removal of the medical condition, medical treatment, or debilitating disease to the board of medicine. A petitioner shall be deemed notified of the denial or recommendation on the date when the board mails the required notification to the petitioner.

154.65(9) Denials. Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the agency's rejection of the petition.

[ARC 3606C, IAB 1/31/18, effective 3/7/18]

641—154.66 to 154.68 Reserved.

LABORATORY TESTING

641—154.69(124E) Requirements of the department.

154.69(1) Laboratory testing requirements and acceptance criteria. The department shall work with manufacturers and laboratories to create and maintain a document describing required sampling methodology, acceptance criteria, stability-testing procedures, and other guidance for manufacturers and laboratories on testing procedures. The department shall provide manufacturers and laboratories no less than 14 days in which to comment on proposed revisions to the document, and the department shall provide no less than 30 days' notice before a revision takes effect. The document shall:

a. Describe the minimum number of sample units and reserve samples required for testing by the laboratory;

b. Describe an option for manufacturers to reduce the amount of testing conducted by allowing compositing of sample units or other techniques that reduce the number of tests required without compromising the safety of the products once a manufacturer has satisfactorily completed a control study for a specific extraction or production process;

c. Describe the minimum requirements for sample size and testing intervals for stability testing;

d. Be available on the department's website (www.idph.iowa.gov).

154.69(2) Review and approval of manufacturer sampling protocols. The department shall have up to two weeks to review and approve or request revisions to a manufacturer's sampling protocols required pursuant to subrules 154.26(2) and 154.26(3).

154.69(3) Review and approval of manufacturer stability-testing procedures. The department shall have up to two weeks to review and approve or request revisions to a manufacturer's stability-testing procedures required pursuant to subrule 154.26(4).

154.69(4) Establish a laboratory review committee. The department shall establish a laboratory review committee to assist with the review of applications by laboratories and the establishment of accepted laboratory testing standards and practices.

[ARC 4078C, IAB 10/10/18, effective 11/14/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.70(124E) Requirements of a laboratory.

154.70(1) Minimum testing requirements. A laboratory shall establish and implement test methods and corresponding standard operating procedures for the analyses of cannabinoids, residual solvents and processing chemicals, pesticides, microbiological impurities, and metals.

154.70(2) Additional tests upon request. A laboratory shall establish and implement test methods and corresponding standard operating procedures for other analyses as requested by the department.

154.70(3) Level of quantitation. A laboratory shall be able to demonstrate that its LOQ is below any action level established by the department.

154.70(4) Inventory tracking.

a. A laboratory shall use the department's secure sales and inventory tracking system, if available, or a manifest system to record the receipt of medical cannabis goods from a manufacturer for testing.

b. A laboratory shall use the department's secure sales and inventory tracking system, if available, or a manifest system to record the return of medical cannabis goods or waste to a manufacturer.

154.70(5) Hazardous waste disposal.

a. A laboratory shall discard hazardous waste, including hazardous waste containing medical cannabis goods, in accordance with federal and state hazardous waste laws.

b. A laboratory shall document the waste disposal procedures followed for each sample.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.71(124E) Requirements of a manufacturer.

154.71(1) *Assuming costs.* A manufacturer shall assume the costs for all laboratory testing requested by the department or laboratory for medical cannabis goods produced by the manufacturer.

154.71(2) *Sample waste retrieval.* A manufacturer shall retrieve analyzed samples and waste containing medical cannabis goods from the laboratory at a duration and frequency approved by the department.

154.71(3) *Obtaining approval for sampling protocols.* A manufacturer shall obtain approval from the department for the manufacturer's sampling protocols pursuant to subrule 154.26(2) prior to submitting samples for laboratory testing related to content and contamination.

154.71(4) *Obtaining approval for stability-testing procedures.* A manufacturer shall obtain approval from the department for the manufacturer's stability-testing procedures pursuant to subrule 154.26(4) prior to submitting samples for laboratory testing related to stability testing and product-expiration-date studies.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18]

641—154.72(124E) Content testing.**154.72(1) *Cannabinoids.***

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall, at minimum, test for and report measurements for the following cannabinoid analytes:

- (1) THC;
- (2) THCA;
- (3) CBD; and
- (4) CBDA.

b. A laboratory shall report that the primary sample passed or failed THC potency testing according to guidance in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).

c. A laboratory shall report that the primary sample passed or failed CBD potency testing according to guidance in the laboratory testing requirements and acceptance criteria document described in subrule 154.69(1).

d. For each cannabinoid analyte test, a laboratory shall issue a certificate of analysis that contains the following:

- (1) Concentrations of cannabinoid analytes in mg/ml for liquids and mg/g for solids, or other measures approved by the department.
- (2) Whether the primary sample passed or failed the test in accordance with paragraph 154.72(1)“b.”

e. The laboratory may test for and provide test results for additional cannabinoid analytes if asked to do so by a requester.

154.72(2) *Contaminants—residual solvents and processing chemicals.*

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall analyze primary samples for residual solvents and processing chemicals.

b. The department shall provide a list of residual solvents and processing chemicals for which primary samples are to be tested with corresponding action levels on the department's website (www.idph.iowa.gov).

c. For each residual solvent or processing chemical for which a primary sample is tested, a laboratory shall report that the primary sample passed the testing if the concentration of residual solvent or processing chemical is at or below the action level approved by the department.

d. For each residual solvent or processing chemical for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of residual solvent or processing chemical is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for residual solvents and processing chemicals and the laboratory determines that a primary sample contains residual solvent or processing chemical analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the residual solvent or processing chemical analytes.

f. The laboratory may test for and provide test results for additional residual solvents or processing chemicals if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each residual solvent or processing chemical for which the primary sample was tested.

1. The concentrations shall be listed in parts per million (ppm) or other units as determined by the department.

2. The laboratory shall report a result of “detected but not quantified” for any target residual solvent or processing chemical that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(2)“*c*” and 154.72(2)“*d*.”

(3) The names and amounts of any additional residual solvents and processing chemicals identified by the laboratory.

h. If the primary sample fails testing for residual solvents and processing chemicals, the lot fails laboratory testing.

i. When a laboratory identifies additional residual solvents and processing chemicals in a primary sample, the laboratory shall:

(1) Notify the department of the additional residual solvents and processing chemicals and the amounts detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(3) Contaminants—pesticides.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for pesticides.

b. The department shall provide a list of pesticides for which primary samples are to be tested with corresponding action levels on the department’s website (www.idph.iowa.gov).

c. For each pesticide for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of pesticide is at or below the action level approved by the department.

d. For each pesticide for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of pesticide is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for pesticides and the laboratory determines that a primary sample contains pesticide analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the pesticide analytes.

f. The laboratory may test for and provide test results for additional pesticides if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each pesticide for which the primary sample was tested.

1. The concentrations shall be listed in parts per million (ppm) or other units as determined by the department.

2. The laboratory shall report a result of “detected but not quantified” for any pesticide that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(3)“c” and 154.72(3)“d.”

(3) The names and amounts of any additional pesticides identified by the laboratory.

h. If the primary sample fails testing for pesticides, the lot fails laboratory testing.

i. When a laboratory identifies additional pesticides in a primary sample, the laboratory shall:

(1) Notify the department of the additional pesticides and the amounts detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(4) Contaminants—metals.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for metals.

b. The department shall provide a list of metals for which primary samples are to be tested with corresponding action levels on the department’s website (www.idph.iowa.gov).

c. For each metal for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of metal is at or below the action level approved by the department.

d. For each metal for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of metal is above the action level approved by the department.

e. If a laboratory is using mass spectrometry instrumentation to analyze primary samples for metals and the laboratory determines that a primary sample contains metal analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the metal analytes.

f. The laboratory may test for and provide test results for additional metals if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name and concentration of each metal for which the primary sample was tested.

1. The concentrations shall be listed in micrograms per gram or other units as determined by the department.

2. The laboratory shall report a result of “detected but not quantified” for any metal that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(4)“c” and 154.72(4)“d.”

(3) The names and amounts of any additional metals identified by the laboratory.

h. If the primary sample fails testing for metals, the lot fails laboratory testing.

i. When a laboratory identifies additional metals in a primary sample, the laboratory shall:

(1) Notify the department of the additional metals and the amounts detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(5) Contaminants—microbiological impurities.

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, the laboratory shall analyze primary samples for microbiological impurities.

b. The department shall provide a list of microbiological impurities for which primary samples are to be tested on the department’s website (www.idph.iowa.gov).

c. For each microbiological impurity for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the microbiological impurity is not detected in 1 gram of matrix or as approved by the department. A primary sample may be reported as passed if a screening procedure yields a negative result or if a presumptively positive result is not found to be positive on the confirmatory procedure.

d. For each microbiological impurity for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the microbiological impurity is detected in 1 gram of matrix or as approved by the department. Confirmatory procedures shall be conducted on all presumptively positive results.

e. If a laboratory is using methods to test primary samples for microbiological impurities and the laboratory determines that a primary sample contains microbiological impurities that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification of the biological impurity.

f. The laboratory may test for and provide test results for additional microbiological impurities if asked to do so by a requester.

g. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

(1) The name of each microbiological impurity for which the primary sample was tested.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.72(5)“*c*” and 154.72(5)“*d*.”

(3) The names of any additional microbiological impurities identified by the laboratory.

h. If the primary sample fails testing for microbiological impurities, the lot fails laboratory testing.

i. When a laboratory identifies additional microbiological impurities in a primary sample, the laboratory shall:

(1) Notify the department of the additional microbiological impurities detected.

(2) Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.72(6) *Additional tests.* The laboratory may perform additional tests if asked to do so by a requester.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4078C, IAB 10/10/18, effective 11/14/18; ARC 4489C, IAB 6/5/19, effective 7/10/19; see Delay note at end of chapter]

641—154.73(124E) Reporting requirements.

154.73(1) *Reporting test results.* The laboratory shall generate a certificate of analysis for each primary sample that it tests and make the certificate of analysis available to the manufacturer who ordered the tests and the department through the department’s secure sales and inventory tracking system, if available, or another laboratory information management system.

154.73(2) *Tentatively identified analytes.* A laboratory shall report on the certificate of analysis any tentatively identified analytes detected during the analysis of the primary sample. When a laboratory identifies additional analytes in a primary sample, the laboratory shall:

a. Notify the department of the additional analytes detected.

b. Refrain from issuing a final certificate of analysis to a manufacturer until given approval to do so by the department.

154.73(3) *Additional reporting requirements.*

a. In addition to the requirements described in rule 641—154.72(124E), the certificate of analysis shall contain, at a minimum, the following information:

(1) All requirements of Standard ISO/IEC 17025;

(2) Date of primary sample collection;

(3) Date the primary sample was received by the laboratory;

(4) Date of each analysis;

(5) The LOQ and action level for each analyte, as applicable;

(6) Whether the primary sample and lot passed or failed laboratory testing; and

(7) A signature by the laboratory quality officer and the date the certificate of analysis was validated as being accurate by the laboratory quality officer.

b. Any test result that is not covered under the laboratory’s ISO/IEC 17025 scope of accreditation shall be clearly identified on the certificate of analysis.

c. Measurements below a method’s limit of detection shall be reported as “<” (less than) or “not detected” and reference the reportable limit. The reporting of zero concentration is not permitted.

d. Measurements \geq LOD but $<$ LOQ shall be reported as “detected but not quantified.”

e. The number of significant figures reported shall reflect the precision of the analysis.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.74(124E) Record-keeping requirements.

154.74(1) Data package. A laboratory shall create a data package for each analytical batch of primary samples that the laboratory analyzes. The data package shall contain at minimum the following information:

- a. The name and address of the laboratory that performed the analytical procedures;
- b. The names, functions, and signatures (electronic or handwritten) of the laboratory personnel that performed the primary sample preparation, analyzed the primary samples, and reviewed and approved the data;
- c. All primary sample and analytical batch quality control sample results;
- d. Raw data for each primary sample analyzed;
- e. Instrument raw data, if any was produced;
- f. Instrument test method with parameters;
- g. Instrument tune report, if one was created;
- h. All instrument standard calibration data;
- i. Test-method worksheets or forms used for primary sample identification, characterization, and calculations, including chromatograms, sample-preparation worksheets, and final datasheets;
- j. The quality control report with worksheets, forms, or copies of laboratory notebook pages containing pertinent information related to the identification and traceability of all reagents, reference materials, and standards used for analysis;
- k. The analytical batch sample sequence;
- l. The field sample log; and
- m. The chain-of-custody form.

154.74(2) Review of data package. After the laboratory has compiled a data package, another individual at the laboratory shall independently review the data package. The reviewer shall:

- a. Assess the analytical results for technical correctness and completeness;
- b. Verify that the results of each analysis carried out by the laboratory are reported accurately, clearly, unambiguously, and objectively;
- c. Verify that the measurements can be traced back; and
- d. Approve the measurement results by signing and dating the data package prior to release of the certificate of analysis by the laboratory.

154.74(3) Data package record retention. The entire data package shall be stored by a laboratory for a minimum of five years and shall be made available upon request by the department or the requester of the laboratory testing.

154.74(4) Other records. A laboratory shall maintain all documents, forms, records, and standard operating procedures associated with the testing of medical cannabis goods.

a. A laboratory shall maintain analytical testing laboratory records in such a manner that the analyst, the date the analysis was performed, the approver of the certificate of analysis, the reviewer and approver of the data package, the test method, and the materials that were used can be determined by the department.

b. Records shall be stored in such a way that the data may be readily retrieved when requested by the department.

c. All testing laboratory records shall be kept for a minimum of five years, unless otherwise noted in these rules.

d. The department shall be allowed access to all electronic data, including standards records, calibration records, extraction logs, and laboratory notebooks.

e. A laboratory shall keep and make available to the department the following records related to the testing of medical cannabis goods:

(1) Personnel qualification, training, and competency documentation, including but not limited to résumés, training records, continuing education records, analytical proficiency testing records, and demonstration of competency records for laboratory work. These records shall be kept current.

(2) Method verification and validation records, including method modification records, method detection limit and quantitation limit determination records, ongoing verification records such as proficiency test records and reference material analysis records.

(3) Quality control and quality assurance records, including the laboratory's quality assurance manual and control charts with control limits.

(4) Chain-of-custody records, including chain-of-custody forms, field sample logs, sample-receipt records, sample-description records, sample-rejection records, laboratory information management system records, sample-storage records, sample-retention records, and disposal records.

(5) Purchasing and supply records, equipment-services records, and other equipment records, including purchase requisition records, packing slips, supplier records, and certificates of analysis.

(6) Laboratory equipment installation records, maintenance records, and calibration records. These records shall include the date and name of the person performing the installation of, calibration of, or maintenance on the equipment, with a description of the work performed, maintenance logs, pipette calibration records, balance calibration records, working and reference mass calibration records, and daily verification-of-calibration records.

(7) Customer service records, including customer contracts, customer requests, certificates of analysis, customer transactions, customer feedback, records related to the handling of complaints and nonconformities, and corrective action pertaining to complaints.

(8) Nonconforming work and corrective action records, including corrective action, nonconformance, nonconformities resolved by correction, customer notification of nonconformities, internal investigations, implementation of corrective action, and resumption-of-work records.

(9) Internal-audit and external-audit records, including audit checklists, standard operating procedures, and audit observation and findings reports. These records shall include the date and name of the person performing the audit.

(10) Management review records, including technical data review reports and final management-review reports. These records shall include the review date and the name of the reviewer.

(11) Laboratory data reports, data review, and data approval records, including instrument and equipment identification records, records with unique sample identifiers, analysts' laboratory notebooks and logbooks, traceability records, test-method worksheets and forms, instrumentation-calibration data, and test-method raw data. These records shall include the analysis date and the name of the analyst.

(12) Proficiency testing records, including the proficiency test schedule, proficiency tests, data-review records, data-reporting records, nonconforming work and corrective actions, and quality control and quality assurance records related to proficiency testing.

(13) Electronic data, backed-up data, records regarding the protection of data, including unprocessed instrument output data files and processed quantitation output files, electronic data protocols and records, and authorized personnel records.

(14) Security data, including laboratory-security records and laboratory-access records, surveillance-equipment records, and security-equipment records. These records shall be stored for at least one year.

(15) Traceability, raw data, standards records, calibration records, extraction logs, reference materials records, analysts' laboratory notebooks and logbooks, supplier records, and certificates of analysis, and all other data-related records.

(16) Laboratory contamination and cleaning records, including autoclave records, acid-wash logs and records, and general laboratory-safety and chemical-hygiene protocols.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

641—154.75(124E) Quality control. The laboratory shall have quality control protocols that include the following elements:

154.75(1) Quality control samples required.

a. The laboratory shall run quality control samples with every analytical batch of samples for chemical and microbiological analysis.

b. For microbiological analysis, the laboratory shall develop procedures for quality control requirements for each analytical batch of samples.

c. The laboratory shall analyze the quality control samples in exactly the same manner as the test samples to validate the laboratory testing results.

154.75(2) *Types of quality control samples.* At a minimum, a laboratory shall have the following quality control samples as part of every analytical batch tested for chemical analytes:

a. Negative control (method blank). A laboratory shall prepare and run at least one method blank sample with an analytical batch of 10 to 20 samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch, to demonstrate that the analytical process did not introduce contamination.

b. Positive control (laboratory control sample). A laboratory shall prepare and run at least one laboratory control sample with an analytical batch of 10 to 20 samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch.

c. Matrix spike sample. A laboratory shall prepare and run one or more matrix spike samples for each analytical batch.

(1) A laboratory shall calculate the percent recovery for quantitative chemical analysis by dividing the sample result by the expected result and multiplying that by 100. All quality control measures shall be assessed and evaluated on an ongoing basis, and quality control acceptance criteria shall be used. When necessary, the department may establish acceptance criteria on the department's website (www.idph.iowa.gov).

(2) If quality control acceptance criteria are not acceptable, a laboratory shall investigate the cause, correct the problem, and rerun the analytical batch of samples. If the problem persists, the laboratory shall reprepare the samples and run the analysis again, if possible.

d. Field duplicate sample. A laboratory shall prepare and run a duplicate sample as described in the laboratory testing requirements and acceptance criteria document in subrule 154.69(1). The acceptance criterion between the primary sample and the duplicate sample is less than or equal to 20 percent relative percent difference.

154.75(3) *Certified reference material for chemical analysis.* The laboratory shall use a reference material for each analytical batch in accordance with the following standards:

a. The reference material should be certified and obtained from an outside source, if possible. If a reference material is not available from an outside source, the laboratory shall make its own in-house reference material.

b. Reference material made in-house should be made from a different source of standards than the source from which the calibration standards are made.

c. The test result for the reference material shall fall within the quality control acceptance criteria. If it does not, the laboratory shall document and correct the problem and run the analytical batch again.

154.75(4) *Calibration standards.* The laboratory shall prepare calibration standards by serially diluting a standard solution to produce working standards used for calibration of an instrument and quantitation of analyses in samples.

154.75(5) *Quality control-sample report.* A laboratory shall generate a quality control-sample report that includes quality control parameters and measurements, analysis date, and type of matrix.

154.75(6) *Limit-of-detection and limit-of-quantitation calculations.* For chemical method analysis, a laboratory shall calculate the limit of detection and limit of quantitation using generally accepted methodology.

[ARC 3836C, IAB 6/6/18, effective 7/11/18; ARC 4489C, IAB 6/5/19, effective 7/10/19]

641—154.76(124E) Security requirements. The department may request assistance from the department of public safety in ensuring a laboratory meets the security requirements in this rule.

154.76(1) *Security policy requirement.* A laboratory shall maintain a security policy to prevent the loss, theft, or diversion of medical cannabis goods and samples. The security policy shall apply to all staff and visitors at a laboratory facility.

154.76(2) Visitor logs. Visitors to a laboratory facility shall sign visitor manifests with name, date, and times of entry and exit, and shall wear badges that are visible at all times and that identify them as visitors.

154.76(3) Restricted access. A laboratory shall use a controlled access system and written manifests to limit entrance to all restricted access areas of its laboratory facility and shall retain a record of all persons who entered the restricted access areas.

a. The controlled access system shall do all of the following:

- (1) Limit access to authorized individuals;
- (2) Maintain a log of individuals with approved access, including dates of approvals and revocations;
- (3) Track times of personnel entry;
- (4) Track times of personnel movement between restricted access areas;
- (5) Store data for retrieval for a minimum of one year; and
- (6) Remain operable in the event of a power failure.

b. Separate written manifests of visitors to restricted areas shall be kept and stored for a minimum of one year if the controlled access system does not include electronic records of visitors to the restricted areas.

c. A laboratory shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

154.76(4) Personnel identification system. A laboratory shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the laboratory facility and that meets the requirements of this subrule and subrule 154.76(2).

a. Requirement for employee identification card. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A laboratory employee shall keep the identification card visible at all times when the employee is in the laboratory.

c. Upon termination or resignation of an employee, a laboratory shall immediately:

- (1) Revoke the employee's access to the laboratory; and
- (2) Obtain and destroy the employee's identification card, if possible.

154.76(5) Video monitoring and surveillance.

a. *Video surveillance system.* A laboratory shall operate and maintain in good working order a video surveillance system for its premises that operates 24 hours per day, seven days a week, and visually records all areas where medical cannabis goods are stored or tested.

b. *Camera specifications.* Cameras shall:

- (1) Capture clear and certain identification of any person entering or exiting a restricted access area containing medical cannabis goods;
- (2) Have the ability to produce a clear, color still photograph live or from a recording;
- (3) Have on all recordings an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
- (4) Continue to operate during a power outage.

c. *Video recording specifications.*

(1) A video recording shall export still images in an industry standard image format, such as .jpg, .bmp, or .gif.

(2) Exported video shall be archived in a format that ensures authentication and guarantees that the recorded image has not been altered.

(3) Exported video shall also be saved in an industry standard file format that can be played on a standard computer operating system.

(4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

d. Additional requirements. A laboratory shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A laboratory shall ensure that 24-hour recordings from all video cameras are:

- (1) Available for viewing by the department upon request;
- (2) Retained for a minimum of 60 days;
- (3) Maintained free of alteration or corruption; and

(4) Retained longer, as needed, if a manufacturer is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

154.76(6) Chain-of-custody policy and procedures. A laboratory shall maintain a current chain-of-custody policy and procedures. The policy should ensure that:

a. Chain of custody is maintained for samples which may have probable forensic evidentiary value; and

b. Annual training is available for individuals who will be involved with testing medical cannabis goods.

154.76(7) Information technology systems security. A laboratory shall maintain information technology systems protection by employing comprehensive security controls that include security firewall protection, antivirus protection, network and desktop password protection, and security patch management procedures.

[ARC 3836C, IAB 6/6/18, effective 7/11/18]

These rules are intended to implement Iowa Code chapter 124E.

[Filed ARC 1640C (Notice ARC 1571C, IAB 8/6/14), IAB 10/1/14, effective 1/30/15]

[Filed Emergency ARC 3150C, IAB 7/5/17, effective 6/13/17]

[Filed ARC 3606C (Notice ARC 3420C, IAB 10/25/17), IAB 1/31/18, effective 3/7/18]

[Filed ARC 3836C (Notice ARC 3707C, IAB 3/28/18), IAB 6/6/18, effective 7/11/18]

[Filed ARC 4078C (Notice ARC 3899C, IAB 7/18/18), IAB 10/10/18, effective 11/14/18]

[Filed ARC 4399C (Notice ARC 4240C, IAB 1/16/19), IAB 4/10/19, effective 5/15/19]

[Filed ARC 4489C (Notice ARC 4363C, IAB 3/27/19), IAB 6/5/19, effective 7/10/19]¹

[Filed ARC 4928C (Notice ARC 4772C, IAB 11/20/19), IAB 2/12/20, effective 6/1/20]²

¹ July 10, 2019, effective date of Items 1, 4, 7, 10, 11, 12, 13, 15, 21, 22, and 24 of **ARC 4489C** delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held July 9, 2019.

² The effective date of **ARC 4928C** was corrected to June 1, 2020, in the March 11, 2020, Iowa Administrative Bulletin.

SOCIAL WORKERS

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CHAPTER 280
LICENSURE OF SOCIAL WORKERS

645—280.1(154C) Definitions. For purposes of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*ASWB*” means the Association of Social Work Boards.

“*Board*” means the board of social work.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*LBSW*” means licensed bachelor social worker.

“*Licensee*” means any person licensed to practice as a social worker in the state of Iowa.

“*License expiration date*” means December 31 of even-numbered years.

“*Licensure by endorsement*” means the issuance of an Iowa license to practice social work to an applicant who is or has been licensed in another state.

“*LISW*” means licensed independent social worker.

“*LMSW*” means licensed master social worker.

“*Mandatory training*” means training on identifying and reporting child abuse or dependent adult abuse required of social workers who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 645—280.14(17A,147,272C) by which an inactive license is restored to active status.

“*Reciprocal license*” means the issuance of an Iowa license to practice social work to an applicant who is currently licensed in another state and that state’s board of examiners has a mutual written agreement with the Iowa board of social work to license persons who have the same or similar qualifications to those required in Iowa.

“*Reinstatement*” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—280.2(154C) Social work services subject to regulation. Social work services provided to an individual in this state through telephonic, electronic or other means, regardless of the location of the social worker, shall constitute the practice of social work and shall be subject to regulation in Iowa.

645—280.3(154C) Requirements for licensure. The following criteria shall apply to licensure:

280.3(1) The applicant shall complete a board-approved application. Application forms may be obtained from the board’s website (www.idph.iowa.gov/licensure) or directly from the board office, or the applicant may complete the application online at ibplicense.iowa.gov. All paper applications shall be

sent to Board of Social Work, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

280.3(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

280.3(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Social Work. The fees are nonrefundable.

280.3(4) No application shall be considered by the board until official copies of academic transcripts have been received by the board except as provided in 280.4(6).

280.3(5) The applicant shall provide verification of license(s) from every state in which the applicant has been licensed as a social worker, sent directly from the state(s) to the Iowa board of social work office.

280.3(6) The candidate shall take the examination(s) required by the board pursuant to these rules.

280.3(7) An applicant for a license as an independent social worker shall have met the requirements for supervision pursuant to 645—280.6(154C).

280.3(8) Each social worker who seeks to attain licensure as an independent social worker shall have been granted a master's or doctoral degree in social work and practiced at that level.

280.3(9) Notification of licensure shall be sent to the licensee by regular mail.

280.3(10) Licensees who were issued their initial licenses within six months prior to the renewal shall not be required to renew their licenses until the renewal date two years later.

280.3(11) Incomplete applications that have been on file in the board office for more than two years shall be:

- a. Considered invalid and shall be destroyed; or
- b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

280.3(12) In lieu of the requirements in subrules 280.3(4) and 280.3(5), the board will accept the ASWB Social Work Registry verification of academic transcripts and verification of licensure in other states.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—280.4(154C) Written examination.

280.4(1) The applicant is required to take and pass the ASWB examination at the appropriate level as follows:

- a. Bachelor level social worker—the basic level examination.
- b. Master level social worker—the intermediate level examination.
- c. Independent level social worker—the clinical level examination.

280.4(2) The electronic examination shall be scheduled with ASWB.

280.4(3) Application for any required examination will be denied or deferred by the board if the applicant lacks the required education or practice experience.

280.4(4) The applicant and the board shall be notified of the ASWB examination results, and the applicant may receive the results at the time of the examination. The board will accept only official results from the ASWB examination service that are sent directly from the examination service to the board.

280.4(5) The ASWB passing score will be utilized as the Iowa passing score.

280.4(6) An applicant may sit for the examination if the applicant meets the requirements stated in 645—280.3(154C). Upon written request of the applicant, the board may authorize a student to sit for the examination prior to the receipt of the official transcript if the student is in the last semester of an approved master of social work program. The student shall submit an application for licensure at the master's level and the fee, and, in lieu of a transcript, the student shall request that the school submit a letter directly to the board office. The letter shall state that the student is currently enrolled in a master of social work program and the student's expected date of graduation. Upon completion of degree requirements, the applicant shall have the transcript showing the date of the degree sent directly

from the school to the board office at the Board of Social Work, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

280.4(7) In lieu of the requirements in subrule 280.4(4), the board will accept the ASWB Social Work Registry verification of the ASWB examination results.

[ARC 8371B, IAB 12/16/09, effective 1/20/10]

645—280.5(154C) Educational qualifications.

280.5(1) Bachelor level social worker. An applicant for a license as a bachelor level social worker shall present evidence satisfactory to the board that the applicant possesses a bachelor's degree in social work from a college or university accredited by the Council on Social Work Education at the time of graduation.

280.5(2) Master level social worker. An applicant for a license as a master level social worker shall present evidence satisfactory to the board that the applicant:

- a. Possesses a master's degree in social work from a college or university accredited by the Council on Social Work Education at the time of graduation; or
- b. Possesses a doctoral degree in social work from a college or university approved by the board at the time of graduation.

280.5(3) Independent level social worker. An applicant for a license as an independent level social worker shall present evidence satisfactory to the board that the applicant:

- a. Possesses a master's degree in social work from a college or university accredited by the Council on Social Work Education at the time of graduation; or
- b. Possesses a doctoral degree in social work from a college or university approved by the board at the time of graduation.

280.5(4) Foreign-trained social workers shall:

a. Provide an equivalency evaluation of their educational credentials by International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, California 90231-3665, telephone (310)258-9451, website www.ierf.org or email at info@ierf.org; or obtain a certificate of equivalency from the Council on Social Work Education, 1701 Duke Street, Suite 200, Alexandria, Virginia 22314-3457, telephone (703)683-8080, website www.csw.org. The professional curriculum must be equivalent to that stated in these rules. The candidate shall bear the expense of the curriculum evaluation.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from a social work program in the country in which the applicant was educated.

c. Receive a final determination from the board regarding the application for licensure.

[ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—280.6(154C) Period of supervised professional practice for LISW. To qualify for licensure at the independent level, an LMSW shall complete a period of supervised professional practice in accordance with the requirements of this rule.

280.6(1) *Minimum requirements.* The period of supervised professional practice shall:

- a. Not begin prior to licensure at the master's level.
- b. Have a duration of at least two calendar years.
- c. Consist of a minimum of 4,000 hours of social work practice at the master's level.
- d. Include at least 110 hours of direct supervision equitably distributed throughout the period and in compliance with the requirements of subrule 280.6(3).
- e. Be done pursuant to one or more written supervision plans that comply with the requirements of subrule 280.6(7).

280.6(2) *Content of supervised professional practice.* The supervisor shall ensure that the period of supervised professional practice includes the following:

- a. Psychosocial assessments, including evaluation of symptoms and behaviors and the effects of the environment on behavior;
- b. Diagnostic practice using the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association;

- c. Treatment, including the establishment of treatment goals, psychosocial therapy, and differential treatment planning;
- d. Practice management skills;
- e. Skills required for continued competence;
- f. Training on ethical standards and legal and regulatory requirements; and
- g. Development of professional identity.

280.6(3) Direct supervision. The required 110 hours of direct supervision may be obtained through individual meetings between the supervisor and supervisee or through group supervision meetings consisting of the supervisor and more than one supervisee.

a. The first supervision meeting must occur in person. After the first supervision meeting, the remaining supervision may occur through in-person meetings or through electronic meetings using an interactive real-time system that provides for visual and audio interaction between the supervisor and supervisee.

b. A maximum of 60 hours of direct supervision may be obtained through group supervision meetings. A maximum of six supervisees may participate in any group supervision meeting.

280.6(4) Supervisor eligibility requirements.

a. To be eligible to serve as a supervisor for the period of supervised professional practice, a social worker shall:

(1) Hold an active license to practice social work at the independent level in Iowa. If the supervised professional practice occurs in another state, a social worker licensed in that state may serve as a supervisor if the social worker is licensed at a level equivalent to the independent level. A social worker licensed in another state may provide direct supervision hours if the social worker is licensed at a level equivalent to the independent level.

(2) Have at least three years of social work practice at the independent level, which must include a minimum of 4,000 hours of practice.

(3) Complete a six-hour continuing education course pertaining to social work practice supervision or one master's level course in supervision.

b. Any request for a supervisor who does not meet these requirements must be submitted to the board for approval before supervision begins. The board will only approve an otherwise ineligible supervisor if the supervisee demonstrates that eligible supervisors are unavailable or unwilling to provide supervision. Any practice or supervision hours obtained under an ineligible supervisor prior to board approval cannot be counted toward completion of the period of supervised professional practice.

280.6(5) Supervisor responsibilities. A supervisor shall provide adequate supervision to all supervisees. Failure to provide adequate supervision may be grounds for disciplinary action. A supervisor shall be responsible for:

- a. Timely submission of the supervision plan;
- b. Providing supervision in accordance with this rule;
- c. Directing the supervisee to obtain written releases of information from patients when legally required for purposes of providing supervision;
- d. Providing periodic evaluations and feedback regarding the supervisee's performance to the supervisee;
- e. Answering questions and assisting supervisees as new or difficult issues arise;
- f. Ensuring the supervisee's caseload is manageable;
- g. Reporting to the board any violations of board rules by supervisees; and
- h. Completing a supervision report.

280.6(6) Supervisee responsibilities. A supervisee shall comply with all statutes and rules governing the practice of social work. A supervisee shall be responsible for:

- a. Timely submission of the supervision plan;
- b. Obtaining supervision in accordance with this rule;
- c. Obtaining written releases of information from patients when legally required for purposes of receiving supervision;

- d. Asking the supervisor to provide periodic evaluations and feedback regarding the supervisee's performance;
- e. Asking questions of the supervisor when assistance is needed or when new or difficult issues arise;
- f. Reporting any issues related to caseload, including volume and difficulty, to the supervisor;
- g. Reporting to the board any violations of board rules by the supervisor; and
- h. Maintaining a copy of every supervision plan and supervision report until such time as the supervisee is issued a license to practice social work at the independent level.

280.6(7) Supervision plan. A current written supervision plan must be maintained throughout the period of supervised professional practice. Each supervisor who provides practice supervision or direct supervision hours shall be named on a supervision plan.

a. A written supervision plan must be established and submitted to the board before the period of supervised professional practice begins. The board will perform an initial review of each supervision plan and notify the supervisee of approval or denial of the plan within 45 days of receipt. A supervisee may begin supervised professional practice after submission of the supervision plan but cannot count any practice or supervision hours obtained pursuant to a supervision plan that is ultimately denied by the board.

b. If a supervisee is changing supervisors or adding an additional supervisor, a revised supervision plan shall be submitted to the board for approval at the time of the change or addition. A supervisee may continue supervised professional practice after submission of a revised supervision plan but cannot count any practice or supervision hours obtained pursuant to a revised supervision plan that is ultimately denied by the board.

c. The board maintains a supervision plan form that may be utilized to write the supervision plan. A supervision plan shall include:

- (1) The name, license number, date of licensure, address, telephone number, and email address of the supervisor;
- (2) The name, license number, address, telephone number, and email address of the supervisee;
- (3) The name of the agency, institution, or organization providing the period of supervised professional practice;
- (4) The start date and estimated date of completion of the period of supervised professional practice;
- (5) The goals and objectives for the period of supervised professional practice;
- (6) The nature, duration, and frequency of direct supervision, including the number of hours of direct supervision per week, the schedule for in-person and electronic supervision meetings, and the use of group supervision; and
- (7) The signatures of the supervisor and supervisee, and the dates of the signatures.

280.6(8) Completion of supervised professional practice.

a. At the conclusion of the period of supervised professional practice, the supervisee shall have any and all supervisors complete a supervision report on the form provided by the board. Each supervision report must be signed and dated by the supervisor and supervisee.

b. The board will review each supervision report for approval of the hours pertaining to the particular report. The board may deny any practice or supervision hours that were not obtained in compliance with this rule. The board may deny any practice or supervision hours if the supervisor indicates that the supervisee did not adhere to the ethical standards and legal and regulatory requirements governing the practice of social work or if the supervisor does not recommend the supervisee for licensure at the independent level.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 8586B, IAB 3/10/10, effective 4/14/10; ARC 0093C, IAB 4/18/12, effective 5/23/12; ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—280.7(154C) Licensure by endorsement. An applicant who has been a licensed social worker under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia, another state, territory, province or foreign country who:

1. Submits to the board a completed application;
2. Pays the licensure fee;
3. Shows evidence of licensure requirements that are similar to those required in Iowa;
4. Provides official copies of the academic transcripts;
5. Provides official copies of the appropriate or higher level examination score sent directly from the ASWB; and
6. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:
 - Licensee's name;
 - Date of initial licensure;
 - Current licensure status; and
 - Any disciplinary action taken against the license.

In lieu of the requirements in numbered paragraphs "4," "5," and "6" of this rule, the board will accept the ASWB Social Work Registry verification of academic transcripts, examination scores, and licensure in other states.

[ARC 0093C, IAB 4/18/12, effective 5/23/12]

645—280.8(154C) Licensure by reciprocal agreement. Rescinded IAB 3/10/10, effective 4/14/10.

645—280.9(154C) License renewal.

280.9(1) The biennial license renewal period for a license to practice social work shall begin on January 1 of odd-numbered years and end on December 31 of the next even-numbered year. Every licensee shall renew on a biennial basis. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of the responsibility for renewing the license.

280.9(2) Renewal procedures.

a. A licensee seeking renewal shall:

(1) Meet the continuing education requirements of rule 645—281.2(154C,272C) and the mandatory reporting requirements of subrule 280.9(3). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

(2) Submit the completed renewal application and renewal fee before the license expiration date.

b. An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the next renewal two years later.

c. Those persons licensed for the first time shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second license renewal may be used. The new licensee will be required to complete a minimum of 27 hours of continuing education per biennium for each subsequent license renewal.

d. Persons licensed to practice social work shall keep their renewal licenses displayed in a conspicuous public place at the primary site of practice.

e. Failure to receive the notice of renewal shall not relieve the licensee of the responsibility for submitting the required materials and the renewal fee to the board office 30 days before license expiration.

f. A social worker whose Iowa license is inactive, delinquent, closed, retired, voluntarily surrendered, suspended, or revoked cannot advance to a higher level until the license is again active.

280.9(3) Mandatory reporting of child abuse and dependent adult abuse.

a. Effective July 1, 2019, a licensee who regularly examines, attends, counsels or treats children in Iowa shall complete an initial two-hour child abuse mandatory reporter training course offered by the department of human services within six months of employment, or prior to the expiration of a current certificate. Thereafter, all mandatory reporters shall take a one-hour recertification training every three years, prior to the expiration of a current certificate.

b. Effective July 1, 2019, a licensee who regularly examines, attends, counsels or treats adults in Iowa shall complete an initial two-hour dependent adult abuse mandatory reporter training course offered by the department of human services within six months of employment, or prior to the expiration of a current certificate. Thereafter, all mandatory reporters shall take a one-hour recertification training every three years, prior to the expiration of a current certificate.

c. 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 645—Chapter 281.

d. The board may select licensees for audit of compliance with the requirements in paragraphs “a” and “b.”

280.9(4) Late renewal. To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

280.9(5) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as a social worker in Iowa until the license is reactivated. A licensee who practices as a social worker in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

280.9(6) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 9934B, IAB 12/28/11, effective 2/1/12; ARC 3744C, IAB 4/11/18, effective 5/16/18; ARC 4981C, IAB 3/11/20, effective 4/15/20]

645—280.10(272C) Exemptions for inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—280.11(272C) Lapsed licenses. Rescinded IAB 8/31/05, effective 10/5/05.

645—280.12(272C) Duplicate certificate or wallet card. Rescinded IAB 3/10/10, effective 4/14/10.

645—280.13(17A,147,272C) License denial. Rescinded IAB 3/10/10, effective 4/14/10.

645—280.14(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

280.14(1) Submit a reactivation application on a form provided by the board.

280.14(2) Pay the reactivation fee that is due as specified in 645—Chapter 284.

280.14(3) Provide verification of current competence to practice social work by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:

1. Licensee’s name;
2. Date of initial licensure;
3. Current licensure status; and

4. Any disciplinary action taken against the license; and
 (2) Verification of completion of 27 hours of continuing education within two years of application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the verifications in both subparagraphs (1) and (2) below plus the verification in either subparagraphs (3) or (4) below.

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 27 hours of continuing education within two years of application for reactivation; and

(3) Verification of passing the ASWB examination within the last five years at the appropriate or higher level as follows:

1. Bachelor level social worker – the bachelor's level examination; or
2. Master level social worker – the master's level examination; or
3. Independent level social worker – the clinical level examination; or

(4) Verification of continued social work practice at the appropriate or higher level in another state for a minimum of two years immediately preceding the application for reactivation.

[ARC 0093C, IAB 4/18/12, effective 5/23/12]

645—280.15(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—280.14(17A,147,272C) prior to practicing social work in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 154C and 272C.

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[Filed ARC 4981C (Notice ARC 4727C, IAB 10/23/19), IAB 3/11/20, effective 4/15/20]

◊ Two or more ARCs

¹ Effective date of rules 161.212 to 161.217 delayed 70 days by the Administrative Rules Review Committee.

² Effective date of 280.100(154C) is July 1, 1993.

³ Effective date of **ARC 9102A** delayed 70 days by the Administrative Rules Review Committee at its meeting held July 13, 1999; delay lifted at the meeting held August 3, 1999, effective August 4, 1999.

CHAPTER 281
CONTINUING EDUCATION FOR SOCIAL WORKERS

645—281.1(154C) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Approved program/activity*” means a continuing education program/activity meeting the standards set forth in these rules.

“*Audit*” means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

“*Board*” means the board of social work.

“*Continuing education*” means planned, organized learning acts acquired during licensure designed to maintain, improve, or expand a licensee’s knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice as a social worker in the state of Iowa.

[ARC 8371B, IAB 12/16/09, effective 1/20/10; ARC 4981C, IAB 3/11/20, effective 4/15/20]

645—281.2(154C) Continuing education requirements.

281.2(1) The biennial continuing education compliance period shall extend for a two-year period beginning on January 1 of each odd-numbered year and ending on December 31 of the next even-numbered year. Each biennium, each person who is licensed to practice as a licensee in this state shall be required to complete a minimum of 27 hours of continuing education approved by the board.

281.2(2) Requirements of new licensees. Those persons licensed for the first time during the license renewal period shall not be required to complete continuing education as a prerequisite for the first renewal of their licenses. Continuing education hours acquired anytime from the initial licensing until the second renewal may be used. The new licensee will be required to complete a minimum of 27 hours of continuing education per biennium for each subsequent license renewal.

281.2(3) Requirement of supervisors. For licensure at the independent level, persons serving in a supervisory role must complete 3 hours of continuing education in supervision.

281.2(4) Hours of continuing education credit may be obtained by attending and participating in a continuing education activity. These hours must be in accordance with these rules.

281.2(5) No hours of continuing education shall be carried over into the next biennium except as stated for the second renewal. A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

281.2(6) It is the responsibility of each licensee to finance the cost of continuing education.

281.2(7) The licensee shall maintain a personal file with all documentation of the continuing education credits obtained.

[ARC 0093C, IAB 4/18/12, effective 5/23/12; ARC 3744C, IAB 4/11/18, effective 5/16/18]

645—281.3(154C,272C) Standards.

281.3(1) General criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit if the continuing education activity:

a. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;

b. Pertains to subject matters which integrally relate to the practice of the profession;

c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program. At the time of audit, the board may request the qualifications of presenters.

d. Fulfills stated program goals, objectives, or both;

e. Provides proof of attendance to licensees in attendance including:

(1) Date, location, course title, presenter(s);

(2) Number of program contact hours; and

(3) Certificate of completion or evidence of successful completion of the course provided by the course sponsor; and

f. Contains one of the following content areas:

(1) Human behavior.

1. Theories and concepts of the development of human behavior in the life cycle of individuals, families and the social environment;

2. Community and organizational theories;

3. Normal, abnormal and addictive behaviors;

4. Abuse and neglect; and

5. Effects of culture, race, ethnicity, sexual orientation and gender.

(2) Assessment and treatment.

1. Psychosocial assessment/interview;

2. Utilization of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association;

3. Theoretical approaches and models of practice—individual, couple, and family therapy and group psychotherapy;

4. Establishing treatment goals and monitoring progress;

5. Techniques of social work practice; and

6. Interdisciplinary consultation and collaboration.

(3) Social work research, program evaluation, or practice evaluation.

(4) Management, administration, and social policy.

1. Organizational policies and procedures;

2. Advocacy and prevention in social work practice;

3. Management of social work staff and other personnel; and

4. Management of social work programs.

(5) Theories and concepts of social work education.

(6) Social work ethics as they pertain to the rules of conduct.

(7) An area, as demonstrated by the licensee, that directly relates to the licensee's individual practice as a social worker. The licensee shall submit for consideration by the board a specific explanation of how the program relates to the licensee's individual practice setting as a social worker.

281.3(2) Specific criteria. Continuing education hours of credit can be obtained by completing:

a. A minimum of three hours per biennium in social work ethics.

b. Academic coursework that meets the criteria set forth in the rules. Continuing education equivalents are as follows:

1 academic semester hour = 15 continuing education hours

1 academic quarter hour = 10 continuing education hours

c. Self-study courses that have a mentor and prior approval as defined in the rules and are accompanied by a brief paper authored by the licensee demonstrating application of the learning objectives to practice issues.

d. Programs designed for the purpose of enhancing the licensee's administrative, management or other clinical skills.

e. Activities/programs that are sponsored/approved by:

(1) ASWB Approved Continuing Education (ACE) Program; or

(2) National Association of Social Workers (NASW) Continuing Education Unit (CEU) Approval Program.

f. Pro-bono/volunteer work that meets the following criteria:

(1) A licensee may earn a maximum of 3 of the required 27 hours of continuing education for credit during one biennium by performing pro-bono/volunteer services for indigent, underserved populations, or in areas of critical need within the state of Iowa. Such services must be approved in advance by the board.

(2) A licensee shall make application for prior approval of pro-bono/volunteer services by sending a letter to the board indicating that the following requirements will be met:

1. The site for these services is identified including information about the clients, the services that will be offered, how they will be performed and the learning objectives.

2. A contract will be established between licensee and client(s), and each party will be aware that the services are being provided without charge.

3. The services will be subject to all the legal responsibilities and obligations related to the licensee's profession.

4. The licensee will keep records and files of these client services pursuant to the rules of 645—Chapter 282.

5. A representative from the site for pro-bono/volunteer services must provide a letter stating that these services are to be performed by the licensee.

6. Upon review, the licensee will receive a letter from the board indicating prior approval for these pro-bono/volunteer services that will be done for continuing education credit.

7. Following completion of such services:

- The licensee must provide the board a letter stating that the services were performed as planned.
- The representative on the site must provide a letter indicating such completion.

g. Instruction of a course at an approved college, university or graduate school of social work. A licensee may receive credit on a one-time basis not to exceed three hours of continuing education credit per biennium.

h. Instruction/presentation/moderation of continuing education programs. A licensee may receive credit on a one-time basis, not to exceed three hours of continuing education credit per biennium, for programs at which the licensee is actually in attendance for the complete program provided the licensee receives a certificate of attendance in compliance with this rule.

i. Authorship of papers, publications or books and preparation of presentations and exhibits. A presentation must be made before a professional audience. Presentations may receive credit on a one-time basis for the article, publication, book or the preparation of a presentation or exhibit, not to exceed three hours of continuing education credit per biennium.

j. Supervision of a social work practicum student(s) from an accredited social work education program. A licensee may receive one credit for every 100 hours supervised, not to exceed six hours of continuing education credit per biennium.

[ARC 3744C, IAB 4/11/18, effective 5/16/18; ARC 4981C, IAB 3/11/20, effective 4/15/20]

645—281.4(154C,272C) Audit of continuing education report. Rescinded IAB 3/10/10, effective 4/14/10.

645—281.5(154C,272C) Automatic exemption. Rescinded IAB 3/10/10, effective 4/14/10.

645—281.6(154C,272C) Continuing education exemption for disability or illness. Rescinded IAB 3/10/10, effective 4/14/10.

645—281.7(154C,272C) Grounds for disciplinary action. Rescinded IAB 3/10/10, effective 4/14/10.

645—281.8(154C,272C) Continuing education exemption for inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—281.9(154C,272C) Continuing education waiver for disability or illness. Rescinded IAB 8/31/05, effective 10/5/05.

645—281.10(154C,272C) Reinstatement of inactive practitioners. Rescinded IAB 8/31/05, effective 10/5/05.

645—281.11(272C) Hearings. Rescinded IAB 8/31/05, effective 10/5/05.

These rules are intended to implement Iowa Code section 272C.2 and chapter 154C.

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ATHLETIC TRAINERS

CHAPTER 351	LICENSURE OF ATHLETIC TRAINERS
CHAPTER 352	CONTINUING EDUCATION FOR ATHLETIC TRAINERS
CHAPTER 353	DISCIPLINE FOR ATHLETIC TRAINERS

CHAPTER 351

LICENSURE OF ATHLETIC TRAINERS

[Prior to 4/17/02, see rules 645—350.6(147,152D) to 645—350.10(147,152D)]

645—351.1(152D) Definitions. For purposes of these rules, the following definitions shall apply:

“Active license” means a license that is current and has not expired.

“Athlete” means a person who participates in a sanctioned amateur or professional sport or other recreational sports activity.

“Athletic injury” means any of the following:

1. An injury or illness sustained by an athlete as a result of the athlete’s participation in sports, games, or recreational sports activities.

2. An injury or illness that impedes or prevents an athlete from participating in sports, games, or recreational sports activities.

“Athletic trainer” means a person licensed under this chapter to practice athletic training under the direction of a licensed physician.

“Athletic training” means the practice of prevention, recognition, assessment, physical evaluation, management, treatment, disposition, and physical reconditioning of athletic injuries that are within the professional preparation and education of a licensed athletic trainer and under the direction of a licensed physician. The term “athletic training” includes the organization and administration of educational programs and athletic facilities, and the education and counseling of the public on matters relating to athletic training.

“Board” means the board of athletic training created under Iowa Code chapter 147.

“BOC” means the Board of Certification or its successor organization.

“Directing physician” means a physician who supervises the athletic training services provided by a licensed athletic trainer.

“Direction” means that a physician directs the performance of a licensed athletic trainer in the development, implementation, and evaluation of an athletic training service plan as set out in 645—351.6(152D). Direction shall not be construed as requiring the personal presence of that physician at each activity of the licensed athletic trainer. It is the responsibility of the licensed athletic trainer to ensure that the practice of athletic training is carried out only under the direction of a licensed physician.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“Licensee” means any person licensed to practice as an athletic trainer in the state of Iowa.

“License expiration date” means February 28 of each odd-numbered year.

“Physical reconditioning” means the part of the practice of athletic training which combines physical treatment, rehabilitation and exercise and is carried out under the orders of a physician or physician assistant. Physical treatment is part of a service plan which includes but is not limited to the continued use of any of the following: cryotherapy, thermotherapy, hydrotherapy, electrotherapy, or the use of mechanical devices.

“Physician” means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, osteopathy, chiropractic, or podiatry under the laws of this state.

“Reactivate” or *“reactivation”* means the process as outlined in rule 645—351.15(17A,147,272C) by which an inactive license is restored to active status.

“Reciprocal license” means the issuance of an Iowa license to practice athletic training to an applicant who is currently licensed in another state which has a mutual agreement with the Iowa board

of athletic training to license persons who have the same or similar qualifications to those required in Iowa.

“*Reinstatement*” means the process as outlined in 645—11.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

645—351.2(152D) Requirements for licensure. The following criteria shall apply to licensure:

351.2(1) The applicant shall complete a board-approved application packet. Application forms may be obtained from the board’s website (idph.iowa.gov/Licensure/Iowa-Board-of-Athletic-Training) or directly from the board office. All applications shall be sent to Board of Athletic Training, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

351.2(2) The applicant shall complete the application form according to the instructions contained in the application. If the application is not completed according to the instructions, the application will not be reviewed by the board.

351.2(3) Each application shall be accompanied by the appropriate fees payable by check or money order to the Board of Athletic Training. The fees are nonrefundable.

351.2(4) No application will be considered by the board until official copies of academic transcripts have been sent directly from the school to the board of athletic training.

351.2(5) The applicant shall successfully complete the BOC examination. It is the responsibility of the applicant to make arrangements to take the examination and have the official results submitted to the Iowa board of athletic training.

351.2(6) Licensees who were issued their licenses within six months prior to the renewal date shall not be required to renew their licenses until the renewal date two years later.

351.2(7) Incomplete applications that have been on file in the board office for more than two years shall be:

- a. Considered invalid and shall be destroyed; or
- b. Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

[ARC 3560C, IAB 1/3/18, effective 2/7/18]

645—351.3(152D) Educational qualifications.

351.3(1) A new applicant for licensure to practice as an athletic trainer shall possess a baccalaureate degree or postbaccalaureate degree from a U.S. regionally accredited college or university.

351.3(2) Foreign-trained athletic trainers shall:

a. Provide an equivalency evaluation of their educational credentials by International Educational Research Foundations, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665; telephone (310)258-9451; website www.ierf.org or email at info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation. An applicant who has passed the BOC examination is exempt from this requirement.

b. Provide a notarized copy of the certificate or diploma awarded to the applicant from an athletic training program in the country in which the applicant was educated. An applicant who has passed the BOC examination is exempt from this requirement.

c. Receive a final determination from the board regarding the application for licensure.

d. Pass the BOC examination. Official results are to be submitted directly to the board from the BOC.

[ARC 3560C, IAB 1/3/18, effective 2/7/18]

645—351.4(152D) Examination requirements.

351.4(1) The examination required by the board shall be the BOC examination. Application and information may be obtained from the BOC Offices, 1415 Harney Street, Suite 200, Omaha, NE 68102; telephone (402)559-0091; website www.bocatc.org or email at BOC@bocatc.org.

351.4(2) The applicant has responsibility for:

- a. Making arrangements to take the national examination; and
- b. Arranging to have the examination scores sent directly to the board from BOC.

[ARC 3560C, IAB 1/3/18, effective 2/7/18]

645—351.5(152D) Documentation of physician direction. Each licensee must maintain documentation of physician direction. It is the responsibility of the licensee to ensure that documentation of physician direction is obtained and maintained, including the following:

1. Athletic training service plan as set out in 645—351.6(152D);
2. Dates and names of physician and physician assistant orders or referrals;
3. Initial evaluations and assessments;
4. Treatments and services rendered, with dates; and
5. Dates of subsequent follow-up care.

645—351.6(152D) Athletic training plan for direct service. Athletic training service plans shall be composed of the following components as taken from the Board of Certification 2000 Standards of Athletic Training for Direct Service and for Service Programs or standards from its successor as determined by the board of athletic training.

351.6(1) Standards for athletic training—direct service.

a. *Standard 1—direction.* The athletic trainer renders service or treatment under the direction of a physician.

b. *Standard 2—injury and ongoing care services.* All services shall be documented in writing by the athletic trainer and shall become part of the athlete's permanent records.

c. *Standard 3—documentation.* The athletic trainer shall accept responsibility for recording details of the athlete's health status. Documentation shall include:

- (1) Athlete's name and any other identifying information.
- (2) Referral source (doctor, dentist).
- (3) Date, initial assessment, results and database.
- (4) Program plan and estimated length.
- (5) Program methods, results and revisions.
- (6) Date of discontinuation and summary.
- (7) Athletic trainer's signature.

d. *Standard 4—confidentiality.* The athletic trainer shall maintain confidentiality as determined by law and shall accept responsibility for communicating assessment results, program plans, and progress with other persons involved in the athlete's program.

e. *Standard 5—initial assessment.* Prior to treatment, the athletic trainer shall assess the athlete's level of functioning. The athlete's input shall be considered an integral part of the initial assessment.

f. *Standard 6—program planning.* The athletic training program objectives shall include long- and short-term goals and an appraisal of those which the athlete can realistically be expected to achieve from the program. Assessment measures to determine the effectiveness of the program shall be incorporated into the plan.

g. *Standard 7—program discontinuation.* The athletic trainer, with the collaboration of the physician, shall recommend discontinuation of the athletic training service when the athlete has received optimal benefit of the program. The athletic trainer, at the time of discontinuation, shall note the final assessment of the athlete's status.

351.6(2) Standards for athletic training—service program. Rescinded IAB 2/2/05, effective 3/9/05.

645—351.7(152D) Licensure by endorsement. An applicant who has been a licensed athletic trainer under the laws of another jurisdiction shall file an application for licensure by endorsement with the board office. The board may receive by endorsement any applicant from the District of Columbia or another state, territory, province or foreign country who:

1. Submits to the board a completed application;

2. Pays the licensure fee;
3. Has the academic transcript(s) sent directly from the school(s) to the board;
4. Shows evidence of licensure requirements that are similar to those required in Iowa;
5. Provides verification of license(s) from every jurisdiction in which the applicant has been licensed, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:
 - Licensee's name;
 - Date of initial licensure;
 - Current licensure status; and
 - Any disciplinary actions taken against the license.
6. Submits evidence:
 - From BOC of current certification status sent directly from BOC to the board, or
 - Of a passing score on the examination of the BOC sent directly from BOC to the board.

645—351.8(147) Licensure by reciprocal agreement. Rescinded IAB 8/13/08, effective 9/17/08.

645—351.9(147) License renewal.

351.9(1) The biennial license renewal period for a license to practice athletic training shall begin on March 1 of each odd-numbered year and end on February 28 of the next odd-numbered year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

351.9(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

351.9(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 645—352.2(152D) and the mandatory reporting requirements of subrule 351.9(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

351.9(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of training in child abuse identification and reporting as required by Iowa Code section 232.69(3)"*b*" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph "*e*."

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of training in dependent adult abuse identification and reporting as required by Iowa Code section 235B.16(5)"*b*" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph "*e*."

c. The course(s) shall be the curriculum provided by the Iowa department of human services.

d. The licensee shall maintain written documentation for three years after mandatory training as identified in paragraphs "*a*" to "*c*," including program date(s), content, duration, and proof of participation.

e. 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.

f. The board may select licensees for audit of compliance with the requirements in paragraphs "*a*" to "*e*."

351.9(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license and shall send the licensee a wallet card by regular mail. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

351.9(6) A person licensed to practice as an athletic trainer shall keep the license certificate and wallet card displayed in a conspicuous public place at the primary site of practice.

351.9(7) 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 645—subrule 5.1(4). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

351.9(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as an athletic trainer in Iowa until the license is reactivated. A licensee who practices as an athletic trainer in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 9967B, IAB 1/11/12, effective 2/15/12; ARC 4982C, IAB 3/11/20, effective 4/15/20]

645—351.10(272C) Exemptions for inactive practitioners. Rescinded IAB 7/20/05, effective 8/24/05.

645—351.11(147) Duplicate certificate or wallet card. Rescinded IAB 8/13/08, effective 9/17/08.

645—351.12(147) Reissued certificate or wallet card. Rescinded IAB 8/13/08, effective 9/17/08.

645—351.13(272C) Lapsed licenses. Rescinded IAB 7/20/05, effective 8/24/05.

645—351.14(17A,147,272C) License denial. Rescinded IAB 8/13/08, effective 9/17/08.

645—351.15(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

351.15(1) Submit a reactivation application on a form provided by the board.

351.15(2) Pay the reactivation fee that is due as specified in 645—Chapter 5.

351.15(3) Provide verification of current competence to practice as an athletic trainer by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 50 hours of continuing education within two years of the application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;

2. Date of initial licensure;
 3. Current licensure status; and
 4. Any disciplinary action taken against the license; and
- (2) Verification of completion of 50 hours of continuing education within two years of application for reactivation; and
- (3) Verification of current BOC certification.

645—351.16(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with 645—11.31(272C) and must apply for and be granted reactivation of the license in accordance with 645—351.15(17A,147,272C) prior to practicing as an athletic trainer in this state.

These rules are intended to implement Iowa Code chapters 17A, 147, 152D and 272C.

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MEDICINE BOARD[653]

[Prior to 5/4/88, see Health Department[470], Chs 135 and 136, renamed Medical Examiners Board[653] under the "umbrella" of Public Health Department[641] by 1986 Iowa Acts, ch 1245]
[Prior to 7/4/07, see Medical Examiners Board[653]; renamed by 2007 Iowa Acts, Senate File 74]

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PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

The board of medicine hereby adopts, with the following exceptions and amendments, rules of the Governor's Task Force on Uniform Rules of Agency Procedure relating to public records and fair information practices which are printed in the first volume of the Iowa Administrative Code.

653—2.1(17A,22) Definitions. As used in this chapter:

"Agency." In lieu of the words "(official or body issuing these rules)", insert "Iowa Board of Medicine".

653—2.3(17A,22) Requests for access to records.

2.3(1) Location of record. In lieu of the words "insert agency head", insert "Iowa Board of Medicine" and in lieu of "insert agency name and address", insert "Iowa Board of Medicine, 400 S.W. 8th Street, Suite C, Des Moines, Iowa 50309-4686".

2.3(2) Office hours. In lieu of "insert customary office hours and if agency does not have customary office hours of at least thirty hours per week, insert hours specified in Iowa Code section 22.4)", insert "the agency's regular business hours, Monday through Friday from 8 a.m. to 4:30 p.m., excluding legal holidays".

2.3(7) Fees.

c. Search and supervisory fees. An hourly fee may be charged for actual agency expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one-quarter hour. The custodian shall prominently post in agency offices the hourly fees to be charged for supervision of records during the examination and copying. That hourly fee shall not be in excess of the hourly wage of an agency employee who ordinarily would be appropriate and suitable to perform this supervisory function.

If the request requires research or if the record or records cannot reasonably be readily retrieved by the office, the requester will be advised of this fact. Reasonable search fees may be charged where appropriate. In addition, all costs for retrieval and copying of information stored in electronic storage systems may be charged to the requester.

653—2.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records. In lieu of the words "designate office" insert the words "Iowa Board of Medicine, 400 S.W. 8th Street, Suite C, Des Moines, Iowa 50309-4686".

653—2.7(17A,22) Consent to disclosure by the subject of a confidential record. Insert at the end of the model rule the following new sentence. "This section does not allow the subject of a record which is confidential under Iowa Code section 272C.6(4) to consent to its release."

653—2.9(17A,22) Disclosures without the consent of the subject.

2.9(1) Open records are routinely disclosed without the consent of the subject.

2.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

- a.* For a routine use as defined in subrule 2.10(1) or in any notice for a particular record system.
- b.* To a recipient who has provided the agency with advance written assurance that the record will be used solely as a statistical research or reporting record, provided that the record is transferred in a form that does not identify the subject.
- c.* To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if an authorized representative of such government agency or instrumentality has

submitted a written request to the agency specifying the record desired and the law enforcement activity for which the record is sought.

- d.* To an individual pursuant to a showing of compelling circumstances affecting the health or safety of an individual if a notice of the disclosure is transmitted to the last-known address of the subject.
- e.* To the legislative services agency.
- f.* Disclosures in the course of employee disciplinary proceedings.
- g.* In response to a court order or subpoena.

653—2.10(17A,22) Routine use.

2.10(1) Defined. “Routine use” means the disclosure of a record without the consent of the subject or subjects, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statute other than the public records law, Iowa Code chapter 22.

2.10(2) To the extent allowed by law, the following uses are considered routine uses of all agency records:

- a.* Disclosure to those officers, employees, investigators, members, and agents of the agency who have a need for the record in the performance of their duties. The custodian of the record may, upon request of any officer, employee, investigator, member, or agent, or on the custodian’s own initiative, determine what constitutes legitimate need to use confidential records.
- b.* Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.
- c.* Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of the agency.
- d.* Disclosure to the attorney general’s office for use in performing its official function.
- e.* Transfers of information within the agency office and among board members; to other state agencies, boards, and departments; to federal agencies; to agencies in other states; Federation of State Medical Boards of the United States, Inc., American Medical Association, American Osteopathic Association, Iowa Medical Society, Iowa Osteopathic Medical Association; Educational Commission for Foreign Medical Graduates; Iowa Physician Assistant Society; Physician’s Assistant Advisory Committee; approved Advanced Care Training facilities; or to local units of government as appropriate to carry out the agency’s statutory authority.
- f.* Information released to the staff of federal or state entities for audit purposes or for purposes of determining whether the agency is operating a program lawfully.
- g.* Any disclosure specifically authorized by the statute under which the record was collected or maintained.
- h.* Transmittal to the district court of the record in a disciplinary hearing, pursuant to Iowa Code section 17A.19(6), regardless of whether the hearing was open or closed.

653—2.11(17A,22) Consensual disclosure of confidential records.

2.11(1) *Consent to disclosure by a subject individual.* To the extent permitted by law, the subject may consent in writing to board disclosure of confidential records as provided in rule 2.7(17A,22).

2.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official’s intervention on behalf of the subject in a matter that involves the agency may to the extent permitted by law be treated as an authorization to release sufficient information about the subject to the official to resolve the matter. This rule does not allow the subject of a record which is confidential under Iowa Code section 272C.6(4) to consent to its release.

653—2.12(17A,22) Release to subject. The subject of a confidential record may file a written request to review confidential records about that person as provided in rule 653—2.6(17A,22). However, the agency need not release the following records to the subject:

1. The identity of a person providing information to the agency need not be disclosed directly or indirectly to the subject of the information when the information is authorized to be held confidential pursuant to Iowa Code sections 22.7(18) and 272C.6(4) or other provision of law.

2. All information in licensee complaint and investigation files maintained by the agency for purposes of licensee discipline are required to be withheld from the subject prior to the filing of formal charges and the notice of hearing in a licensee disciplinary proceeding.

3. Records need not be disclosed to the subject when they are the work product of an attorney or are otherwise privileged.

4. Peace officers' investigative reports may be withheld from the subject, except as required by the Iowa Code.

5. As otherwise authorized by law.

653—2.13(17A,22) Availability of records.

2.13(1) Open records. Agency records are open for public inspection and copying unless otherwise provided by rule or law.

2.13(2) Confidential records. The following records may be withheld from public inspection. Records are listed by category, according to the legal basis for withholding them from public inspection.

a. Tax records made available to the agency. (Iowa Code sections 422.70 and 422.72)

b. Records which are exempt from disclosure under Iowa Code section 22.7.

c. All complaint files, investigative files, other investigation reports, and other investigation information maintained by the agency for purposes of licensee discipline are confidential. (Iowa Code section 272C.6(4))

(1) This information may be released to the licensee once a licensee disciplinary proceeding has been initiated by the filing of formal charges and a notice of hearing. (Iowa Code section 272C.6)

(2) The agency may disclose the investigative file, reports and other information to appropriate licensing authorities within this state or the appropriate licensing authorities in another state, territory or country in which the licensee is licensed or has applied for a license. (Iowa Code section 272C.6(4))

(3) If the investigative information in the possession of the agency indicates a crime has been committed, the information shall be reported to the proper law enforcement agency. However, a final written decision and finding of fact in a disciplinary proceeding, including a decision referred to in Iowa Code section 272C.3, subsection 4, is a public record. (Iowa Code section 272C.6(4))

d. Information relating to the contents of an examination for licensure. (Iowa Code section 147.21)

e. Information relating to the results of an examination for licensure other than final score except for information about the results of an examination which is given to the person who took the examination. (Iowa Code section 147.21)

f. Information contained in professional substance abuse reports or other investigative reports relating to the abuse of controlled substances. (Iowa Code chapter 125 and section 228.2 and 42 U.S.C. 290 dd-2)

g. Minutes and tape recordings of portions of meetings held in closed session. (Iowa Code section 21.5(4))

h. The record of a disciplinary hearing which is closed to the public pursuant to Iowa Code section 272C.6(1). (Iowa Code section 21.5(4))

i. Identifying details in final orders, decisions and opinions to the extent required to prevent a clearly unwarranted invasion of personal privacy or trade secrets under Iowa Code section 17A.3(1) "e." (Iowa Code sections 21.5(3) and 21.5(18))

j. Records which constitute attorney work product or attorney-client communications or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10, and 622.11, Iowa R. Civ.P. 1.503, Fed.R. Civ.P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.

k. Any other information or records made confidential by law.

2.13(3) Authority to release confidential records. The agency may have discretion to disclose some confidential records which are exempt from disclosure under Iowa Code section 22.7 or other law. Any person may request permission to inspect records withheld from inspection under a statute which authorized limited or discretionary disclosure as provided in rule 653—2.4(17A,22). If the agency initially determines that it will release such records, the agency may where appropriate notify interested parties and withhold the records from inspection as provided in subrule 2.4(3).

2.13(4) Notwithstanding any statutory confidentiality provision, the board may share information with the child support recovery unit and the department of revenue through manual or automated means for the sole purpose of identifying licensees or applicants subject to enforcement under Iowa Code chapter 252J, 272D or 598.

[ARC 9337B, IAB 1/12/11, effective 2/16/11; ARC 4979C, IAB 3/11/20, effective 4/15/20]

653—2.14(17A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by the agency by personal identifier in record systems as defined in rule 2.1(17A,22). For each record system, this rule describes the legal authority for the collection of that information and the means of storage of that information. The description also indicates whether the record system contains any confidential information, and includes the legal authority for confidentiality. The records systems maintained by the agency are:

2.14(1) *Records of agency disciplinary hearings.* These records contain information about licensees and certificants who are the subject of an agency disciplinary proceeding or other action. This information is collected by the agency pursuant to the authority granted in Iowa Code chapters 147, 147A, 148, 148C, and 272C. This information is stored electronically and on paper. The information contained in “records of closed” board hearings is confidential in whole or in part pursuant to Iowa Code sections 21.5(4) and 272C.6 or other provisions of the law.

2.14(2) *Information in complaint and investigation files maintained by the agency for purposes of licensee discipline.* This information is required to be kept confidential pursuant to Iowa Code section 272C.6(4). However, it may be released to the licensee once a disciplinary proceeding is commenced by the filing of formal charges and the notice of hearing.

2.14(3) *Information on nonlicensee investigation files maintained by the agency.* This information is a public record except to the extent that certain information may be exempt from disclosure under Iowa Code section 22.7 or other provision of the law.

2.14(4) *Licensee disciplinary proceedings.* The following information regarding licensee disciplinary proceedings:

- a. Formal charges and notices of hearing.
- b. Completed records of open disciplinary hearings. If a hearing is closed pursuant to Iowa Code section 272C.6(1), the record is confidential under Iowa Code section 21.5(4) or 272C.6.
- c. Final written decisions imposing sanctions, including informal stipulations and settlements; or dismissing the charges, in whole or in part.

2.14(5) *Continuing education records.* These records contain educational information about persons licensed or certified by the agency. This information is collected pursuant to the authority granted in Iowa Code chapter 272C. This information is stored on paper only.

2.14(6) *Examination records.* These records contain information about applicants for any of the following examinations: United States Medical Licensing Examination (USMLE), Federation of State Medical Boards of the United States, Inc. - Federation Licensing Examination (FLEX), National Board of Medical Examiners, National Board of Osteopathic Medical Examiners, National Commission for the Certification of Acupuncturists, individual state or territorial medical licensing boards, Licentiate of the Medical Council of Canada examination (LMCC), Special Purpose Examination (SPEX), or other examination approved by the board. These records may also contain information about applicants who pursue licensure by endorsement, score transfer, or other means. The information is collected by the agency pursuant to the authority granted in Iowa Code chapters 147, 148, and 148E and is stored

electronically and on paper. Portions of the examination records are confidential in part pursuant to Iowa Code sections 22.7(1), 22.7(19), and 147.21.

2.14(7) *Investigative reports.* These records contain information about the subjects of board investigations and the activities of board investigators and agents. The records include a variety of attachments such as interviews; drug audits; medical records; pharmacy records; exhibits; police reports; and investigators' comments, conclusions, and recommendations. This information is collected by the agency pursuant to the authority granted in Iowa Code chapters 147, 147A, 148, and 148C. This information is stored electronically on microfilm and on paper. The information contained in these records is confidential in whole or in part pursuant to Iowa Code sections 22.7, 147.21, and 272C.6(4).

2.14(8) *Licensure and certification records.* These records contain information about doctors of medicine and surgery and osteopathic medicine and surgery; and registered acupuncturists who are licensed or registered by the agency. The information is collected by the agency pursuant to the authority granted in Iowa Code chapters 147, 148, and 148E and is stored on paper, in automated data processing systems, on microfiche, on CD-ROM, floppy disk, and in the state archives. These records may contain information which is confidential under subrule 2.13(2).

2.14(9) *Personnel records.* These records contain personal information about board members, registered peer review committee members, and staff. The files include payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship. This information is stored on paper and microfiche. The personal information contained in these records may be confidential in whole or in part pursuant to Iowa Code section 22.7.

2.14(10) *Routine probation supervision reports.* These reports contain information about licensees or certificants who have been placed on professional probation as the result of an official agency disciplinary action and contain information relating to the licensees' or certificants' compliance with the terms of probation and are confidential under Iowa Code section 272C.6.

2.14(11) *Routine consent agreement monitoring reports.* These reports contain information about licensees or certificants who have been granted licensure or certification under special terms and conditions through official agency action, and contain information relating to the licensees' or certificants' compliance with the terms of the consent agreement and are confidential under Iowa Code section 272C.6.

653—2.15(17A,22) Other groups of records. This rule describes groups of records maintained by the agency other than record systems as defined in rule 653—2.1(17A,22). These records are routinely available to the public. The agency's files of these records may contain confidential information as discussed in rule 653—2.13(17A,22). These records may contain information about individuals. These records include:

2.15(1) *Agency calendars, agenda, news releases, statistical reports and compilations, newsletters, publications, correspondence, and other information intended for the public.* These records may contain information about individuals, including board members and staff. This information is stored on paper only.

2.15(2) *Minutes of open meetings of the agency.* These records contain information about people who participate in board meetings. This information is collected pursuant to Iowa Code section 21.3. This information is stored electronically and on paper.

2.15(3) *Records of board rule-making proceedings.* These records may contain information about individuals making written or oral comments on rules proposed by the agency. This information is collected pursuant to Iowa Code section 17A.4. This information is stored electronically and on paper.

2.15(4) *Board decisions, findings of fact, final orders, advisory opinions, and other statements of law, policy, or declaratory rulings issued by the agency in the performance of its function.* These records are open to the public except for information that is confidential according to rule 653—2.13(17A,22). This information is stored on paper and on microfilm.

2.15(5) Other records. The agency maintains other records which do not generally contain information pertaining to individuals. These records are routinely open to the public. These records include but are not limited to:

- a. Financial reports pertaining to the agency's budget including its revenue and expenses. This information is stored electronically and on paper.
- b. Blank forms utilized by the agency and its staff in the performance of its function. This information is stored on paper only.
- c. Grant proposals and applications submitted by, on behalf of, or in conjunction with the agency for the purpose of performing the agency's function or furthering its goals and objectives. This information is stored on paper only.
- d. A record inventory of all categories of information and records maintained by or on behalf of the board. This inventory is stored on paper only.

653—2.16(17A,22) Data processing system. The agency does not currently have a data processing system which matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

653—2.17(17A,22) Applicability.

2.17(1) This chapter implements Iowa Code section 22.11 by establishing agency policies and procedures for the maintenance of records.

2.17(2) This chapter does not:

1. Require the agency to index or retrieve records which contain information about individuals by that person's name or other personal identifier.
2. Make available to the general public records which would otherwise not be available under the public records law, Iowa Code chapter 22.
3. Govern the maintenance or disclosure of, notification of or access to, records in the possession of the agency which are governed by rules of another board or agency.
4. Apply to guarantees, including local governments or subdivisions thereof, administering state-funded programs.
5. Make available records compiled by the agency in reasonable anticipation of court litigation or formal administrative disciplinary proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable rules of the agency.

These rules are intended to implement Iowa Code section 22.11.

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CHAPTER 11
CONTINUING EDUCATION AND
TRAINING REQUIREMENTS

[Prior to 5/4/88, see 470—135.101 to 470—135.110 and 135.501 to 135.512]

653—11.1(272C) Definitions.

“*ABMS*” means the American Board of Medical Specialties, which is an umbrella organization for at least 24 medical specialty boards in the United States that assists the specialty boards in developing and implementing educational and professional standards to evaluate and certify physician specialists in the United States. The board recognizes specialty board certification by ABMS.

“*Accredited provider*” means an organization approved as a provider of category 1 credit by one of the following board-approved accrediting bodies: Accreditation Council for Continuing Medical Education, Iowa Medical Society, or the Council on Continuing Medical Education of the AOA.

“*Active duty*” means full-time training or active service in the U.S. armed forces, reserves or national guard.

“*Active licensee*” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in Iowa who has met all conditions of licensure and maintains a current license to practice in Iowa.

“*AMA*” means the American Medical Association, a professional organization of physicians and surgeons.

“*AOA*” means the American Osteopathic Association, which is the representative organization for osteopathic physicians (D.O.s) in the United States. The board approves osteopathic medical education programs with AOA accreditation; the board approves AOA-accredited resident training programs in osteopathic medicine and surgery at hospitals for graduates of accredited osteopathic medical schools. The board recognizes specialty board certification by AOA. The board recognizes continuing medical education accredited by the Council on Continuing Medical Education of AOA.

“*Approved abuse education training program*” means a training program using a curriculum approved by the abuse education review panel of the department of public health or a training program offered by a hospital, a professional organization for physicians, or the department of human services, the department of education, an area education agency, a school district, the Iowa law enforcement academy, an Iowa college or university, or a similar state agency.

“*Approved program or credit*” means any category 1 credit offered by an accredited provider or any other program or credit meeting the standards set forth in these rules.

“*Board*” means the Iowa board of medicine.

“*Carryover*” means hours of category 1 credit earned in excess of the required hours in a license period that may be applied to the continuing education requirement in the subsequent license period; carryover may not exceed 20 hours of category 1 credit per renewal cycle.

“*Category 1 credit*” means any formal education program which is sponsored or jointly sponsored by an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, or the Council on Continuing Medical Education of the AOA that is of sufficient scope and depth of coverage of a subject area or theme to form an educational unit and is planned, administered and evaluated in terms of educational objectives that define a level of knowledge or a specific performance skill to be attained by the physician completing the program. Credits designated as formal cognates by the American College of Obstetricians and Gynecologists or as prescribed credits by the American Academy of Family Physicians are accepted as equivalent to category 1 credits.

“*Committee*” means the licensure committee of the board.

“*COMVEX-USA*” means the Comprehensive Osteopathic Medical Variable-Purpose Examination for the United States of America. The National Board of Osteopathic Medical Examiners prepares the examination and determines its passing score. A licensing authority in any jurisdiction administers the examination. COMVEX-USA is the current evaluative instrument offered to osteopathic physicians who need to demonstrate current osteopathic medical knowledge.

“*Continuing education*” means education that is acquired by a licensee in order to maintain, improve, or expand skills and knowledge present at initial licensure or to develop new and relevant skills and knowledge.

“*Hour of continuing education*” means a clock hour spent by a licensee in actual attendance at or completion of an approved category 1 credit.

“*Inactive license*” means any license that is not a current, active license. Inactive license may include licenses formerly known as delinquent, lapsed, or retired. A physician whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice medicine under an Iowa license until the license is reinstated.

“*Licensee*” means any person licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa.

“*Opioid*” means any FDA-approved product or active pharmaceutical ingredient classified as a controlled substance that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain.

“*Service charge*” means the amount charged for making a service available on line and is in addition to the actual fee for a service itself. For example, one who renews a license on line will pay the license renewal fee and a service charge.

“*SPEX*” means Special Licensure Examination prepared by the Federation of State Medical Boards and administered by a licensing authority in any jurisdiction. The passing score on SPEX is 75.

“*Training for chronic pain management*” means required training on chronic pain management identified in 653—Chapter 11.

“*Training for end-of-life care*” means required training on end-of-life care identified in 653—Chapter 11.

“*Training for identifying and reporting abuse*” means training on identifying and reporting child abuse or dependent adult abuse required of physicians who regularly provide primary health care to children or adults, respectively. The full requirements on reporting of child abuse and the training requirements are in Iowa Code section 232.69; the full requirements on reporting of dependent adult abuse and the training requirements are in Iowa Code section 235B.16.

[ARC 9601B, IAB 7/13/11, effective 8/17/11; ARC 0217C, IAB 7/25/12, effective 8/29/12; ARC 0871C, IAB 7/24/13, effective 8/28/13; ARC 4338C, IAB 3/13/19, effective 4/17/19]

653—11.2(272C) Continuing education credit and alternatives.

11.2(1) Continuing education credit may be obtained by attending category 1 credits as defined in this chapter.

11.2(2) The board shall accept the following as equivalent to 50 hours of category 1 credit: participation in an approved resident training program or board certification or recertification by an ABMS or AOA specialty board within the licensing period.

11.2(3) The board shall in January of each year recognize the equivalent of up to 10 hours of category 1 credits for physicians who actively served as members or alternate members of the Iowa board of medicine during the previous year; for physicians who actively served as members of the Iowa physician health committee during the previous year; and for physicians who performed peer reviews for the board during the previous year. The physicians receiving recognition of category 1 credit equivalents will be notified by U.S. mail in January by the executive director of the board.

[ARC 0217C, IAB 7/25/12, effective 8/29/12]

653—11.3(272C) Accreditation of providers. The board approves the Accreditation Council for Continuing Medical Education, the Iowa Medical Society, and the Council on Continuing Medical Education of the AOA as organizations acceptable to accredit providers of category 1 credits.

[ARC 0217C, IAB 7/25/12, effective 8/29/12]

653—11.4(272C) Continuing education and training requirements for renewal or reinstatement. A licensee shall meet the requirements in this rule to qualify for renewal of a permanent license, an

administrative medicine license, or special license or to qualify for reinstatement of a permanent license or an administrative medicine license.

11.4(1) Continuing education and training requirements.

a. Continuing education for permanent license or administrative medicine license renewal. Except as provided in these rules, a total of 40 hours of category 1 credit or board-approved equivalent shall be required for biennial renewal of a permanent license or an administrative medicine license. This may include up to 20 hours of credit carried over from the previous license period and category 1 credit acquired within the current license period.

(1) To facilitate license renewal according to birth month, a licensee's first license may be issued for less than 24 months. The number of hours of category 1 credit required of a licensee whose license has been issued for less than 24 months shall be reduced on a pro-rata basis.

(2) A licensee desiring to obtain credit for carryover hours shall report the carryover, not to exceed 20 hours of category 1 credit, on the renewal application.

b. Continuing education for special license renewal. A total of 20 hours of category 1 credit shall be required for annual renewal of a special license. No carryover hours are allowed.

c. Training for identifying and reporting child and dependent adult abuse for permanent or special license renewal. The licensee in Iowa shall complete the training for identifying and reporting child and dependent adult abuse as part of a category 1 credit or an approved training program. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.4(1)"a."

(1) Training to identify child abuse. A licensee who regularly provides primary health care to children in Iowa must complete at least two hours of training provided by the department of human services pursuant to Iowa Code section 232.69(3)"c" in child abuse identification and reporting every three years. If a licensee completes at least one hour of additional child abuse identification and reporting training prior to the three-year expiration period, the licensee shall be deemed in compliance with the training requirements of this subparagraph for an additional three years. "A licensee who regularly provides primary health care to children" means all emergency physicians, family physicians, general practice physicians, pediatricians, and psychiatrists, and any other physician who regularly provides primary health care to children.

(2) Training to identify dependent adult abuse. A licensee who regularly provides primary health care to adults in Iowa must complete at least two hours of training provided by the department of human services pursuant to Iowa Code section 235B.16(5)"c" in dependent adult abuse identification and reporting every three years. If a licensee completes at least one hour of additional dependent adult abuse identification and reporting training prior to the three-year expiration period, the licensee shall be deemed in compliance with the training requirements of this subparagraph for an additional three years. "A licensee who regularly provides primary health care to adults" means all emergency physicians, family physicians, general practice physicians, internists, obstetricians, gynecologists, and psychiatrists, and any other physician who regularly provides primary health care to adults.

d. Training for chronic pain management for permanent or special license renewal. The licensee shall complete the training for chronic pain management as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.4(1)"a."

(1) A licensee who has prescribed opioids to a patient during the previous license period must complete at least two hours of category 1 credit regarding the United States Centers for Disease Control and Prevention (CDC) guideline for prescribing opioids for chronic pain, including recommendations on limitations on dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacologic therapy options, every five years. A licensee may attest as part of the license renewal process that the licensee is not subject to the requirement to receive continuing medical education credits pursuant to this paragraph, due to the fact that the licensee did not prescribe opioids to a patient during the previous licensure cycle.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the chronic pain management training and shall then complete the training once every five years thereafter.

e. Training for end-of-life care for permanent or special license renewal. The licensee shall complete the training for end-of-life care as part of a category 1 credit. The licensee may utilize category 1 credit received for this training during the license period in which the training occurred to meet continuing education requirements in paragraph 11.4(1) “a.”

(1) A licensee who regularly provides direct patient care to actively dying patients in Iowa must complete at least two hours of category 1 credit for end-of-life care every five years.

(2) A licensee who had a permanent or special license on January 1, 2019, has until January 1, 2024, to complete the end-of-life care training and shall then complete the training once every five years thereafter.

11.4(2) Exemptions from renewal requirements.

a. A licensee shall be exempt from the continuing education requirements in subrule 11.4(1) when, upon license renewal, the licensee provides evidence for:

(1) Periods that the licensee served honorably on active duty in the U.S. armed forces, reserves or national guard;

(2) Periods that the licensee practiced in another state or district and did not provide medical care, including telemedicine services, to patients located in Iowa, if the other state or district had continuing education requirements for the profession and the licensee met all requirements of that state or district for practice therein;

(3) Periods that the licensee was a government employee working in the licensee’s specialty and assigned to duty outside the United States; or

(4) Other periods of active practice and absence from the state approved by the board.

b. The requirements for training on chronic pain management and end-of-life care for license renewal shall be suspended for a licensee who provides evidence for:

(1) Periods described in subparagraph 11.4(2) “a” (1), (2), (3), or (4); or

(2) Periods that the licensee resided outside of Iowa and did not practice in Iowa.

11.4(3) Extension for completion of or exemption from renewal requirements. The board may, in individual cases involving physical disability or illness, grant an extension of time for completion of, or an exemption from, the renewal requirements in subrule 11.4(1).

a. A licensee requesting an extension or exemption shall complete and submit a request form to the board that sets forth the reasons for the request and has been signed by the licensee and attending physician.

b. The board may grant an extension of time to fulfill the requirements in subrule 11.4(1).

c. The board may grant an exemption from the educational requirements for any period of time not to exceed one calendar year.

d. If the physical disability or illness for which an extension or exemption was granted continues beyond the period of waiver, the licensee must reapply for a continuance of the extension or exemption.

e. The board may, as a condition of any extension or exemption granted, require the applicant to make up a portion of the continuing education requirement by methods it prescribes.

11.4(4) Reinstatement requirement. An applicant for license reinstatement whose license has been inactive for one year or more shall provide proof of successful completion of 40 hours of category 1 credit completed within 24 months prior to submission of the application for reinstatement or proof of successful completion of SPEX or COMVEX-USA within one year immediately prior to the submission of the application for reinstatement.

11.4(5) Cost of continuing education and training for renewal or reinstatement. Each licensee is responsible for all costs of continuing education and training required in 653—Chapter 11.

11.4(6) Documentation. A licensee shall maintain documentation of the continuing education and training requirements in 653—Chapter 11, including dates, subjects, duration of programs, and proof of participation, for five years after the date of the continuing education and training.

11.4(7) Audits. The board may audit continuing education and training documentation at any time within the five- or three-year period, as applicable. If the board conducts an audit of continuing education and training, a licensee shall respond to the board and provide all materials requested, within 30 days of a request made by board staff or within the extension of time if one has been granted.

11.4(8) Grounds for discipline. A licensee may be subject to disciplinary action for failure to comply with continuing education and training requirements in 653—Chapter 11.

[ARC 9601B, IAB 7/13/11, effective 8/17/11; ARC 0217C, IAB 7/25/12, effective 8/29/12; ARC 0871C, IAB 7/24/13, effective 8/28/13; ARC 2523C, IAB 5/11/16, effective 6/15/16; see Rescission note at end of chapter; ARC 4338C, IAB 3/13/19, effective 4/17/19; ARC 4978C, IAB 3/11/20, effective 4/15/20]

653—11.5(272C) Failure to fulfill requirements for continuing education and training for identifying and reporting abuse.

11.5(1) Disagreement over whether material submitted fulfills the requirements specified in rule 653—11.4(272C).

a. Staff will attempt to work with a licensee or applicant to resolve any discrepancy concerning credit for renewal or reinstatement.

b. When resolution is not possible, staff shall refer the matter to the committee.

(1) In the matter of a licensee seeking license renewal, staff shall renew the license if all other matters are in order and inform the licensee that the matter is being referred to the committee.

(2) In the matter of an applicant seeking reinstatement, staff shall reinstate the license if all other matters are in order and inform the applicant that the matter is being referred to the committee.

c. The committee shall consider the staff's recommendation for denial of credit for continuing education or training for identifying and reporting abuse, chronic pain management, and end-of-life care.

(1) If the committee approves the credit, it shall authorize the staff to inform the licensee or applicant that the matter is resolved.

(2) If the committee disapproves the credit, it shall refer the matter to the board with a recommendation for resolution.

d. The board shall consider the committee's recommendations.

(1) If the board approves the credit, it shall authorize the staff to notify the licensee or applicant for reinstatement if all other matters are in order.

(2) If the board denies the credit, it shall:

1. Close the case;

2. Send the licensee or applicant an informal, nonpublic letter of warning, which may include recommended terms for complying with the requirements for continuing education or training; or

3. File a statement of charges for noncompliance with the board's rules on continuing education or training and for any other violations which may exist.

11.5(2) Informal appearance for failure to complete requirements for continuing education or training.

a. The licensee or applicant may, within ten days after the date that the notification of the denial was sent by certified mail, request an informal appearance before the board.

b. At the informal appearance, the licensee or applicant will have the opportunity to present information, and the board will issue a written decision.

[ARC 9601B, IAB 7/13/11, effective 8/17/11; ARC 0217C, IAB 7/25/12, effective 8/29/12]

653—11.6(17A,147,148E,272C) Waiver or variance requests. Waiver or variance requests shall be submitted in conformance with 653—Chapter 3.

These rules are intended to implement Iowa Code chapters 147 and 272C and sections 232.69 and 235B.16.

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¹ Paragraph 11.4(1)“d” rescinded by 2018 Iowa Acts, House File 2377, section 23, effective 7/1/18.

CHAPTER 16
STUDENT LOAN DEFAULT OR NONCOMPLIANCE
Rescinded **ARC 4979C**, IAB 3/11/20, effective 4/15/20

CHAPTER 18
MILITARY SERVICE AND VETERAN RECIPROCITY

653—18.1(272C) Definitions. As used in this chapter:

“*License*” means a license issued by the board, including a permanent medical license, resident physician license, special physician license, temporary physician license or licensed acupuncturist license.

“*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 that is subject to the jurisdiction of the board for military education, training, or service obtained or completed in military service including, but not limited to, a medical physician or surgeon, osteopathic physician or surgeon, or licensed acupuncturist.

“*Provisional license*” means a license that is issued by the board to a veteran who is licensed in another jurisdiction in which licensure requirements are not substantially equivalent to those required in Iowa and that will allow the veteran an opportunity to obtain additional experience or education required for licensure in Iowa. A provisional license may be issued 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.

“*Spouse*” means the spouse of an active duty member of the military forces of the United States.

“*Veteran*” means an individual who meets the definition of “veteran” in Iowa Code section 35.1(2). [ARC 1804C, IAB 12/24/14, effective 1/28/15; ARC 4980C, IAB 3/11/20, effective 4/15/20]

653—18.2(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.

18.2(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.

18.2(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.

18.2(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).

18.2(4) The applicant shall fully comply with all other requirements necessary for licensure in Iowa pursuant to 653—Chapter 9.

18.2(5) 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 qualifications for licensure.

18.2(6) 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.

18.2(7) 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.

18.2(8) 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. There shall be no fees

or costs assessed against the military service applicant in connection with a contested case conducted pursuant to this subrule.

18.2(9) 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 application be placed on pending status. The withdrawal of a licensure application shall not preclude subsequent applications supported by additional documentation or information.

[ARC 1804C, IAB 12/24/14, effective 1/28/15]

653—18.3(272C) Veteran and spouse reciprocity.

18.3(1) A veteran or spouse with an unrestricted professional license in another jurisdiction may apply for licensure in Iowa through reciprocity. A veteran or spouse must pass any examinations required for licensure to be eligible for licensure through reciprocity. A fully completed application for licensure submitted by an applicant under this subrule shall be given priority and shall be expedited.

18.3(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. In addition, the applicant shall provide such documentation as is reasonably needed to verify the applicant's status as a veteran under Iowa Code section 35.1(2) or as a spouse.

18.3(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 or spouse is licensed are substantially equivalent to the licensing requirements in Iowa. The board may consider the following factors in determining substantial equivalence: scope of practice, education and coursework, degree requirements, and postgraduate experiences.

18.3(4) The board shall promptly grant a license to the veteran or spouse if the veteran or spouse 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 malpractice history or criminal background.

18.3(5) If the board determines that the licensing requirements in the jurisdiction in which the veteran or spouse is licensed are not substantially equivalent to those required in Iowa, the board shall promptly inform the applicant 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 malpractice history or criminal background, the following shall apply:

a. If the applicant has not passed the required examination(s) for licensure, the applicant may request that the application be placed in pending status.

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.

18.3(6) A veteran or spouse 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. There shall be no fees or costs assessed against the veteran or spouse in connection with a contested case conducted pursuant to this subrule.

[ARC 1804C, IAB 12/24/14, effective 1/28/15; ARC 4980C, IAB 3/11/20, effective 4/15/20]

These rules are intended to implement Iowa Code chapters 147, 148, 148E, and 272C.

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[Filed ARC 4980C (Notice ARC 4805C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]

CHAPTER 20
LICENSURE OF GENETIC COUNSELORS

653—20.1(148H) Purpose. The licensure of genetic counselors is established to ensure that practitioners are qualified to provide to Iowans genetic counseling with reasonable skill and safety. The provisions of Iowa Code chapters 147, 148H, and 272C authorize the board of medicine to establish eligibility requirements for licensure, evaluate the credentials of applicants for licensure, issue licenses to qualified applicants, institute continuing education requirements, investigate complaints and reports alleging that licensed genetic counselors have violated statutes and rules governing the practice of genetic counseling, make available participation in the Iowa physician health program, and discipline licensed genetic counselors found guilty of infractions as provided in state law and board rules. [ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.2(148H) Scope of chapter. This chapter shall not be construed to apply to any of the following:

1. A physician or surgeon or an osteopathic physician or surgeon licensed under Iowa Code chapter 148, a registered nurse or an advanced registered nurse practitioner licensed under Iowa Code chapter 152, a physician assistant licensed under Iowa Code chapter 148C, or other persons licensed under Iowa Code chapter 147 when acting within the scope of the person's profession and doing work of a nature consistent with the person's education and training.
2. A person who is certified by the American Board of Medical Genetics and Genomics as a doctor of philosophy and is not a genetic counselor licensed pursuant to Iowa Code chapter 148H.
3. A person employed as a genetic counselor by the federal government or an agency thereof if the person provides genetic counseling services solely under the direction and control of the entity by which the person is employed.
4. A genetic counseling intern.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.3(148H) Definitions.

“Active candidate status” means a person has met the requirements established by the American Board of Genetic Counseling to take the American Board of Genetic Counseling certification examination in general genetics and genetic counseling and has been granted this designation by the American Board of Genetic Counseling.

“American Board of Genetic Counseling” or *“ABGC”* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

“American Board of Medical Genetics and Genomics” or *“ABMGG”* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

“Board” means the board of medicine.

“Committee” means the licensure committee of the board.

“Genetic counseling” means the provision of services by a person who qualifies for a license under Iowa Code chapter 148H.

“Genetic counseling intern” means a student enrolled in a genetic counseling program accredited by the accreditation council for genetic counseling or the American Board of Medical Genetics and Genomics.

“Genetic counselor” means a person who is licensed under Iowa Code chapter 148H to engage in the practice of genetic counseling.

“Qualified supervisor” means any person who is a genetic counselor licensed under Iowa Code chapter 148H, a physician licensed under Iowa Code chapter 148, or an advanced registered nurse practitioner licensed under Iowa Code chapter 152.

“Supervision” means supervision by a qualified supervisor who has the overall responsibility of assessing the work of a provisional licensee, provided that an annual supervision contract signed by the

qualified supervisor and the provisional licensee is on file with both parties. “Supervision” does not require the qualified supervisor’s presence during the performance of services.
[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.4(148H) Scope of practice. A person licensed pursuant to Iowa Code chapter 148H may do any of the following:

1. Obtain and evaluate individual, family, and medical histories to determine genetic risk for genetic and medical conditions and diseases in a patient, the patient’s offspring, and other family members.
2. Discuss the features, history, means of diagnosis, genetic and environmental factors, and management of risk for genetic and medical conditions and diseases.
3. Identify, order, and coordinate genetic laboratory tests and other diagnostic studies as appropriate for the genetic assessment of a patient.
4. Refer a patient to a specialty or subspecialty department as necessary for the purpose of collaborating on diagnosis and treatment involving multiple body systems and general medical management.
5. Integrate genetic laboratory test results and other diagnostic studies with personal and family medical history to assess and communicate risk factors for genetic and medical conditions and diseases.
6. Explain the clinical implications of genetic laboratory tests and other diagnostic studies and their results.
7. Evaluate the responses of a patient or patient’s family to the condition or risk of recurrence and provide patient-centered genetic counseling and anticipatory guidance.
8. Identify and utilize community resources that provide medical, educational, financial, and psychosocial support and advocacy.
9. Provide written documentation of medical, genetic, and counseling information for families and health care professionals.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.5(148H) Titles used. A genetic counselor licensed under Iowa Code chapter 148H may use the words “genetic counselor” or “licensed genetic counselor” or the corresponding abbreviation “LGC” after the person’s name. Persons who possess a provisional license shall add the designation “provisional licensed genetic counselor.”

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.6(148H) Qualifications for licensure.

20.6(1) Each applicant for licensure under Iowa Code chapter 148H shall:

- a. Submit an application form and supporting documentation as prescribed by the board.
- b. Hold active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

20.6(2) A licensee shall maintain active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.7(148H) Qualifications for provisional licensure. The board may issue a provisional license to an applicant who meets all of the requirements for licensure except for the certification component and who has been granted active candidate status by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

20.7(1) The applicant shall submit a provisional license application form, proof of active candidate status, and supporting documentation prescribed by the board.

20.7(2) A provisional license shall expire and become inactive upon the earliest of the following:

- a. Issuance of a license as a genetic counselor by the board.
- b. Loss of active candidate status.

(1) A person holding a provisional license which is inactive due to loss of active candidate status may submit an application for reactivation of the provisional license upon demonstrating that active candidate status has been reestablished.

(2) An application for extension of a provisional license shall be signed by a qualified supervisor.

- c. The date printed on the provisional license.

20.7(3) A person with a provisional license shall work at all times under the supervision of a qualified supervisor.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.8(147,148H) Application requirements.

20.8(1) *Application for licensure.* To apply for a license to practice genetic counseling, an applicant shall:

- a. Submit the completed application form provided by the board, including required credentials and documents, a completed fingerprint packet and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

- b. Pay the nonrefundable initial application fee identified in 653—paragraph 8.14(2) “a” and pay the fee identified in 653—paragraph 8.14(2) “f” for the evaluation of the fingerprint packet and the national criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

20.8(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

- a. The applicant’s full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

- b. A photograph of the applicant suitable for positive identification;

- c. A chronology accounting for all time periods from the date the applicant entered a genetic counseling training program or educational institution to the date of the application;

- d. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice genetic counseling, including license, certificate of registration or certification number and date of issuance;

- e. Full disclosure of the applicant’s involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process;

- f. A statement disclosing and explaining any informal or nonpublic actions, such as letters of warning, letters of education, any confidential retraining, or any kind of confidential action taken toward a genetic counselor’s certification or license which is not public discipline; warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;

- g. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

- h. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure;

- i. A statement of the applicant’s physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in the practice of genetic counseling and provide patients with safe and healthful care; and

j. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

20.8(3) Application cycle. If the applicant does not submit all materials, including a completed fingerprint packet, within 90 days of the board's initial request for further information, the application shall be considered inactive. The board office shall notify the applicant of this change in status.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 653—paragraph 8.14(2)“*b*” and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, an applicant must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

20.8(4) Applicant responsibilities. An applicant for licensure to practice genetic counseling bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national certifying organizations, health facilities, and educational institutions providing the information specified in subrule 20.8(2);

b. Providing accurate, up-to-date, and truthful information on the application form including, but not limited to, that specified under subrule 20.8(2) related to prior professional experience, education, training, active certification, licensure, and disciplinary history.

20.8(5) Licensure application review process. A process established by the board shall be utilized to review each application. Priority shall be given to processing a licensure application when a written request is received in the board office from an applicant whose practice will primarily involve provision of services to underserved populations, including but not limited to persons who are minorities or low-income or who live in rural areas.

a. An application for initial licensure shall be considered open from the date the application form is received in the board office with the nonrefundable initial application fee.

b. After reviewing each application, staff shall notify the applicant about how to resolve any problems identified by the reviewer. An applicant shall provide additional information when requested by staff or the board.

c. If the final review indicates that the application is complete and that the application does not raise any questions or concerns regarding the applicant's qualifications for licensure, staff may administratively issue the license. Staff may issue the license without having received a report on the applicant from the FBI.

d. If the final review indicates questions or concerns that cannot be remedied by continued communication with the applicant, the executive director, the director of licensure and the director of legal affairs shall determine if the questions or concerns indicate any uncertainty about the applicant's current qualifications for licensure.

(1) If there is no current concern, staff shall administratively issue the license.

(2) If there are questions or concerns, an Iowa-licensed genetic counselor may be consulted.

(3) If any concern exists, staff shall refer the application to the committee.

e. Staff shall refer to the committee for review matters which include, but are not limited to, falsification of information on the application, criminal record, malpractice, substance abuse, competency, physical or mental illness, or professional disciplinary history.

f. If the committee is able to eliminate questions or concerns without dissension from staff or a committee member, the committee may direct staff to issue the license administratively.

g. If the committee is not able to eliminate questions or concerns without dissension from staff or a committee member, and after consultation with an Iowa-licensed genetic counselor, the committee shall recommend that the board:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

1. Successfully complete board-approved continuing education or remediation;
2. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board;
3. If the genetic counselor is employed or has an offer of employment, successfully complete any other pathway as agreed upon by the board and the genetic counselor's employer;

(4) Issue a license;

(5) Issue a license under certain terms and conditions or with certain restrictions;

(6) Request that the applicant withdraw the licensure application; or

(7) Deny a license.

h. The board shall consider applications and recommendations from the committee and shall:

(1) Request an investigation;

(2) Request that the applicant appear for an interview;

(3) If an applicant has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

1. Successfully complete board-approved continuing education or remediation;

2. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board;

3. If the genetic counselor is employed or has an offer of employment, successfully complete any other pathway as agreed upon by the board and the genetic counselor's employer;

(4) Issue a license;

(5) Issue a license under certain terms and conditions or with certain restrictions;

(6) Request that the applicant withdraw the licensure application; or

(7) Deny a license. The board may deny a license for any grounds on which the board may discipline a license.

20.8(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, and after consultation with an Iowa-licensed genetic counselor, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in this chapter pursuant to Iowa Code section 148H.3.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148H.7 or in rule 653—20.20(147,148H,272C).

20.8(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board shall issue a preliminary notice of denial that shall be sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and shall cite the factual and legal basis for denying the application, notify the applicant of the appeal process, and specify the date upon which the denial will become final if it is not appealed.

20.8(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board shall consider the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

20.8(9) Hearing. If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing shall be a contested case and subsequent proceedings shall be conducted in accordance with rule 653—25.30(17A).

- a. License denial hearings are contested cases open to the public.
- b. Either party may request issuance of a protective order in the event privileged or confidential information is submitted into evidence.
- c. Evidence supporting the denial of the license may be presented by an assistant attorney general.
- d. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.
- e. The board, after a hearing on license denial, may issue or deny the license. The board shall state the reasons for its decision and may issue the license, issue the license with restrictions, or deny the license. The final decision is a public record.
- f. Judicial review of a final order of the board denying licensure, or issuing a license with restrictions, may be sought in accordance with the provisions of Iowa Code section 17A.19, which are applicable to judicial review of any agency's final decision in a contested case.

20.8(10) Finality. If an applicant does not appeal a preliminary notice of denial in accordance with subrule 20.8(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

20.8(11) Failure to pursue appeal. If an applicant appeals a preliminary notice of denial in accordance with subrule 20.8(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice shall state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

20.8(12) Waiver or variance prohibited. Provisions of this rule are not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4468C, IAB 6/5/19, effective 5/15/19; ARC 4728C, IAB 10/23/19, effective 11/27/19]

653—20.9(147,148H) Display of license and notification required to change the board's data system.

20.9(1) Display of license. Licensed genetic counselors shall display the license issued by the board in a conspicuous place in their primary place of business.

20.9(2) Change of contact information. Licensees shall notify the board within one month of a change in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board.

20.9(3) Change of full legal name. A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

20.9(4) Deceased. A licensee's file shall be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.10(147,148H,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148H.3, a license expires on October 31 of odd-numbered years and can be renewed for the fee identified in 653—paragraph 8.14(2) "c."

20.10(1) The applicant for renewal shall provide:

- a. A renewal application provided by the board.
- b. A letter sent directly from the ABGC or ABMGG to the board verifying that the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a

letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

c. Satisfactory evidence to the board that in the period since the license was issued or last renewed, the applicant has completed 30 hours of National Society of Genetic Counselors or ABMGG continuing education units as approved by the board.

20.10(2) Expiration date. Certificates of licensure to practice genetic counseling shall expire on October 31 in odd years.

20.10(3) Prorated fees. The first renewal fee for a license shall be prorated on a monthly basis according to the date of issue.

20.10(4) Renewal requirements and penalties for late renewal. Each licensee shall be sent a renewal notice at least 60 days prior to the expiration date. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive the notice does not relieve the licensee of responsibility for renewing that license.

a. When online renewal is used, the licensee must complete the online renewal prior to midnight on December 31 in order to ensure that the license will not become inactive. The license becomes inactive and invalid at 12:01 a.m. on January 1.

b. Upon receipt of the completed renewal application, staff shall administratively issue a license that expires on October 31 of odd-numbered years. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration.

c. Every renewal shall be displayed in connection with the original certificate of licensure.

d. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty fee identified in 653—paragraph 8.14(2) “*d*” shall be assessed for renewal in the grace period, a period up until January 1 when the license becomes inactive if not renewed.

20.10(5) Inactive license. Failure of a licensee to renew by January 1 will result in invalidation of the license, and the license will become inactive.

a. Licensees are prohibited from engaging in the practice of genetic counseling once the license is inactive.

b. Having a genetic counselor license in inactive status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148H.7.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4468C, IAB 6/5/19, effective 5/15/19; ARC 4728C, IAB 10/23/19, effective 11/27/19]

653—20.11(147,272C) Reinstatement of an inactive license.

20.11(1) Reinstatement requirements. Licensees who allow their licenses to go inactive by failing to renew may apply for reinstatement of a license. Pursuant to Iowa Code section 147.11, applicants for reinstatement shall:

a. Submit upon forms provided by the board a completed application for reinstatement of a license to practice genetic counseling. The application shall include the following information:

(1) The applicant’s full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant’s involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority; an educational institution; a training or research program; or a health facility in any jurisdiction.

(5) A statement of the applicant's physical and mental health, including full disclosure and a written explanation of any dysfunction or impairment which may affect the ability of the applicant to engage in practice and provide patients with safe and healthful care.

(6) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(7) A chronology accounting for all time periods from the date of initial licensure.

(8) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 653—paragraph 8.14(2) “*f*” for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reinstatement fee identified in 653—paragraph 8.14(2) “*g*” plus the fee identified in 653—paragraph 8.14(2) “*f*” for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from the ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

e. Meet any new requirements instituted since the license lapsed.

20.11(2) Reinstatement for an applicant who has been out of practice for three years. If an applicant for reinstatement has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

a. Successfully complete board-approved continuing education or remediation.

b. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board.

c. Successfully complete any other pathway as agreed upon by the board.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4468C, IAB 6/5/19, effective 5/15/19; ARC 4728C, IAB 10/23/19, effective 11/27/19]

653—20.12(272C) Code of ethics. The NSGC Code of Ethics prepared and approved by the National Society of Genetic Counselors shall be utilized by the board as guiding principles in the practice of genetic counseling in this state.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.13(272C) Nonpayment of state debt. 653—Chapter 12 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.14(272C) Standards of practice—office practices. Rule 653—13.7(147,148,272C) shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.15(272C) Iowa physician health committee. 653—Chapter 14 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.16(272C) Child support noncompliance. 653—Chapter 15 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.17(272C) Student loan default or delinquency—prohibited grounds for discipline. The board shall not suspend or revoke a license issued by the board to a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or

public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

[ARC 4979C, IAB 3/11/20, effective 4/15/20]

653—20.18(272C) Military service and veteran reciprocity. 653—Chapter 18 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.19(272C) Mandatory reporting. 653—Chapter 22 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.20(147,148H,272C) Grounds for discipline of genetic counselors. The board has authority to impose discipline for any violation of Iowa Code chapter 147, 148H, or 272C or the rules promulgated thereunder. These grounds for discipline apply to genetic counselors. This rule is not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law. The board may impose any of the disciplinary sanctions set forth in 653—subrule 25.25(1), when the board determines that the licensee is guilty of any of the following acts or offenses:

20.20(1) Violating any of the grounds for revocation or suspension of a license as listed in Iowa Code section 147.55, 148H.7, or 272C.10.

20.20(2) Professional incompetency. Professional incompetency includes, but is not limited to, any of the following:

- a.* Willful or repeated gross malpractice;
- b.* Willful or gross negligence;
- c.* A substantial lack of knowledge or ability to discharge professional obligations within the scope of the genetic counselor's practice;
- d.* A substantial deviation by the genetic counselor from the standards of learning or skill ordinarily possessed and applied by other genetic counselors in the state of Iowa acting in the same or similar circumstances;
- e.* A failure by a genetic counselor to exercise in a substantial respect that degree of care which is ordinarily exercised by an average genetic counselor in the state of Iowa acting in the same or similar circumstances;

f. A willful or repeated departure from or failure to conform to the minimal standard of acceptable and prevailing practice of genetic counseling in the state of Iowa.

20.20(3) Practice harmful or detrimental to the public. Practice harmful or detrimental to the public includes, but is not limited to, the failure of the genetic counselor to possess and exercise that degree of skill, learning, and care expected of a reasonable, prudent genetic counselor acting in the same or similar circumstances in this state, or when a genetic counselor is unable to practice genetic counseling with reasonable skill and safety as a result of mental or physical impairment, or chemical abuse.

20.20(4) Unprofessional conduct. Engaging in unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice, or good morals, whether the act is committed in the scope of the licensee's practice or otherwise, and whether the act is committed in this state or elsewhere; or a violation of the principles of ethics applicable to genetic counselors.

20.20(5) Sexual misconduct. Engaging in sexual misconduct includes, but is not limited to, a genetic counselor engaging in conduct set forth in 653—subrule 13.7(4) (sexual conduct) or 13.7(6) (sexual harassment) as interpreted by the board.

20.20(6) Substance abuse. Substance abuse includes, but is not limited to, excessive use of alcohol, drugs, narcotics, chemicals, or other substances in a manner which may impair a licensee's ability to practice the profession with reasonable skill and safety.

20.20(7) Physical or mental impairment. Physical or mental impairment includes, but is not limited to, any physical, neurological, or mental condition which may impair a genetic counselor's ability to practice the profession with reasonable skill and safety. Being adjudicated mentally incompetent by a court of competent jurisdiction shall automatically suspend a license for the duration of the license unless the board orders otherwise.

20.20(8) Felony criminal conviction. Being convicted of a felony in the courts of this state, another state, the United States, or any country, territory, or jurisdiction, as defined in Iowa Code section 148.6(2) “b.”

20.20(9) Violation of the laws or rules governing the practice of genetic counseling in this state, another state, the United States, or any country, territory, or jurisdiction. Violation of the laws or rules governing the practice of genetic counseling includes, but is not limited to, willful or repeated violation of the provisions of these rules or the provisions of Iowa Code chapter 147, 148H, or 272C or any other state or federal laws governing the practice of genetic counseling.

20.20(10) Violation of a lawful order of the board, previously entered by the board in a disciplinary or licensure hearing, or violation of the terms and provisions of a consent agreement or settlement agreement entered into between a licensee and the board.

20.20(11) Violation of an initial agreement or health contract entered into with the Iowa physician health program (IPHP).

20.20(12) Failure to comply with an evaluation order under Iowa Code section 272C.9(1).

20.20(13) Knowingly making misleading, deceptive, untrue, or fraudulent representations in the practice of genetic counseling. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of genetic counseling includes, but is not limited to, an intentional perversion of the truth, either orally or in writing, by a genetic counselor in the practice of genetic counseling.

20.20(14) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice genetic counseling in this state, and includes false representations of material fact, either by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or attempting to file or filing with the board any false or forged document submitted with an application for license in this state.

20.20(15) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes, but is not limited to, a licensee’s having made misleading, deceptive, or untrue representations as to the genetic counselor’s competency to perform professional services for which the licensee is not qualified to perform by education, training, or experience.

20.20(16) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making known to the public information which is false, deceptive, misleading, or promoted through fraud or misrepresentation and includes statements which may consist of, but are not limited to:

- a. Inflated or unjustified claims which lead to expectations of favorable results;
- b. Self-laudatory claims that imply that the licensee is skilled in a field or specialty for which the licensee is not qualified;
- c. Representations that are likely to cause an average person to misunderstand; or
- d. Extravagant claims or claims of extraordinary skill not recognized by the profession of genetic counseling.

20.20(17) Obtaining any fee by fraud or misrepresentation.

20.20(18) Acceptance of remuneration for referral of a patient to other health professions in violation of the law or National Society of Genetic Counselors Code of Ethics.

20.20(19) Knowingly submitting a false report of continuing education or failure to submit the required reports of continuing education.

20.20(20) Knowingly aiding, assisting, procuring, or advising a person in the unlawful practice of genetic counseling.

20.20(21) Failure to report disciplinary action. Failure to report a license revocation, suspension, or other disciplinary action taken against a licensee by a professional licensing authority of another state, an agency of the United States government, or any country, territory, or other jurisdiction, within 30 days of final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board.

20.20(22) Failure to report voluntary agreements. Failure to report any voluntary agreement to restrict the practice of genetic counseling entered into with this state, another state, the United States, an agency of the federal government, or any country, territory or other jurisdiction.

20.20(23) Failure to notify the board within 30 days after occurrence of any settlement or adverse judgment of a malpractice claim or action.

20.20(24) Failure to comply with a valid subpoena issued by the board pursuant to Iowa Code sections 17A.13 and 272C.6.

20.20(25) Failure to submit to a board-ordered mental, physical, clinical competency, or substance abuse evaluation or a drug or alcohol screening.

20.20(26) Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary proceedings under this rule shall follow the procedures set forth in Iowa Code chapter 252J and 653—Chapter 15.

20.20(27) Rescinded IAB 3/11/20, effective 4/15/20.

20.20(28) Improper management of medical records. Improper management of medical records includes, but is not limited to, failure to maintain timely, accurate, and complete medical records.

20.20(29) Failure to respond to or comply with a board investigation initiated pursuant to Iowa Code section 272C.3 and rule 653—24.2(17A,147,148,272C).

20.20(30) Failure to submit an additional completed fingerprint card and applicable fee, within 30 days of a request made by board staff, when a previous fingerprint submission has been determined to be unacceptable.

20.20(31) Failure to respond to the board or submit continuing education materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one has been granted.

20.20(32) Failure to respond to the board or submit requested mandatory training for identifying and reporting abuse materials during a board audit, within 30 days of a request made by the board staff or within the extension of time if one has been granted.

20.20(33) Nonpayment of state debt as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 272D and 653—Chapter 12.

20.20(34) Failure to file with the board a written report and a copy of the hospital disciplinary action within 30 days of any hospital disciplinary action or the licensee's voluntary action to avoid a hospital disciplinary action, as required by rule 653—22.5(272C).

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter; ARC 4979C, IAB 3/11/20, effective 4/15/20]

653—20.21(272C) Complaints and investigations. 653—Chapter 24 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.22(272C) Contested case proceedings. 653—Chapter 25 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.23(272C) Reinstatement after disciplinary action. 653—Chapter 26 shall apply to licensed genetic counselors.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.24(148H,272C) Surrender of license to the board.

20.24(1) A genetic counselor whose license is suspended or revoked or whose surrender of license with or without prejudice has been accepted by the board shall promptly surrender the original license to the board.

20.24(2) A genetic counselor whose ABGC certification has lapsed or whose certification has been revoked by the ABGC shall surrender the genetic counselor's license to the board.

20.24(3) A provisional licensee who loses active candidate status with the ABGC must immediately cease the practice of genetic counseling until the provisional licensee obtains an extension of the provisional license or obtains a new provisional license.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

653—20.25(147,148H,272C) Waiver or variance prohibited. Fees in this chapter are not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law.

[ARC 4339C, IAB 3/13/19, effective 4/17/19; see Delay note at end of chapter]

These rules are intended to implement Iowa Code chapters 147, 148, 148H, and 272C.

[Filed ARC 4339C (Notice ARC 4095C, IAB 10/24/18), IAB 3/13/19, effective 4/17/19]¹

[Filed Emergency ARC 4468C, IAB 6/5/19, effective 5/15/19]

[Filed ARC 4728C (Notice ARC 4477C, IAB 6/5/19), IAB 10/23/19, effective 11/27/19]

[Filed ARC 4979C (Notice ARC 4806C, IAB 12/18/19), IAB 3/11/20, effective 4/15/20]

¹ April 17, 2019, effective date of Chapter 20 [ARC 4339C] delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 2019; delay lifted at the meeting held May 14, 2019.

CHAPTER 23
GROUNDS FOR DISCIPLINE
[Prior to 7/19/06, see 653—Chapter 12]

653—23.1(272C) Grounds for discipline. The board has authority to impose discipline for any violation of Iowa Code chapter 147, 148, 148E, 252J, or 272C or 2008 Iowa Acts, Senate File 2428, division II, or the rules promulgated thereunder. The grounds for discipline apply to physicians and acupuncturists. This rule is not subject to waiver or variance pursuant to 653—Chapter 3 or any other provision of law. The board may impose any of the disciplinary sanctions set forth in 653—subrule 25.25(1), including civil penalties in an amount not to exceed \$10,000, when the board determines that the licensee is guilty of any of the following acts or offenses:

23.1(1) Violating any of the grounds for the revocation or suspension of a license as listed in Iowa Code section 147.55, 148.6, 148E.8 or 272C.10.

23.1(2) Professional incompetency. Professional incompetency includes, but is not limited to, any of the following:

- a.* Willful or repeated gross malpractice;
- b.* Willful or gross negligence;
- c.* A substantial lack of knowledge or ability to discharge professional obligations within the scope of the physician's or surgeon's practice;
- d.* A substantial deviation by the physician from the standards of learning or skill ordinarily possessed and applied by other physicians or surgeons in the state of Iowa acting in the same or similar circumstances;
- e.* A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances;
- f.* A willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery or osteopathic medicine and surgery in the state of Iowa;
- g.* Failure to meet the acceptable and prevailing standard of care when delegating or supervising medical services provided by another physician, health care practitioner, or other individual who is collaborating with or acting as an agent, associate, or employee of the physician responsible for the patient's care, whether or not injury results.

23.1(3) Practice harmful or detrimental to the public. Practice harmful or detrimental to the public includes, but is not limited to, the failure of a physician to possess and exercise that degree of skill, learning and care expected of a reasonable, prudent physician acting in the same or similar circumstances in this state, or when a physician is unable to practice medicine with reasonable skill and safety as a result of a mental or physical impairment or chemical abuse.

23.1(4) Unprofessional conduct. Engaging in unethical or unprofessional conduct includes, but is not limited to, the committing by a licensee of an act contrary to honesty, justice or good morals, whether the same is committed in the course of the licensee's practice or otherwise, and whether committed within this state or elsewhere; or a violation of the standards and principles of medical ethics or 653—13.7(147,148,272C) or 653—13.20(147,148) as interpreted by the board.

23.1(5) Sexual misconduct. Engaging in sexual misconduct includes, but is not limited to, engaging in conduct set out at 653—subrule 13.7(4) or 13.7(6) as interpreted by the board.

23.1(6) Substance abuse. Substance abuse includes, but is not limited to, excessive use of alcohol, drugs, narcotics, chemicals or other substances in a manner which may impair a licensee's ability to practice the profession with reasonable skill and safety.

23.1(7) Indiscriminately or promiscuously prescribing, administering or dispensing any drug for other than lawful purpose includes, but is not limited to:

- a.* Self-prescribing or self-dispensing controlled substances.
- b.* Prescribing or dispensing controlled substances to members of the licensee's immediate family.

(1) Prescribing or dispensing controlled substances to members of the licensee's immediate family is allowable for an acute condition or on an emergency basis when the licensee conducts an examination, establishes a medical record, and maintains proper documentation.

(2) Immediate family includes the physician's spouse or domestic partner and either of the physician's, spouse's, or domestic partner's parents, stepparents or grandparents; the physician's natural or adopted children or stepchildren and any child's spouse, domestic partner or children; the siblings of the physician or the physician's spouse or domestic partner and the sibling's spouse or domestic partner; or anyone else living with the physician.

23.1(8) Physical or mental impairment. Physical or mental impairment includes, but is not limited to, any physical, neurological or mental condition which may impair a physician's ability to practice the profession with reasonable skill and safety. Being adjudged mentally incompetent by a court of competent jurisdiction shall automatically suspend a license for the duration of the license unless the board orders otherwise.

23.1(9) Felony criminal conviction. Being convicted of a felony in the courts of this state, another state, the United States, or any country, territory or other jurisdiction, as defined in Iowa Code section 148.6(2) "b."

23.1(10) Violation of the laws or rules governing the practice of medicine or acupuncture of this state, another state, the United States, or any country, territory or other jurisdiction. Violation of the laws or rules governing the practice of medicine includes, but is not limited to, willful or repeated violation of the provisions of these rules or the provisions of Iowa Code chapter 147, 148, 148E or 272C or other state or federal laws or rules governing the practice of medicine.

23.1(11) Violation of a lawful order of the board, previously entered by the board in a disciplinary or licensure hearing, or violation of the terms and provisions of a consent agreement or settlement agreement entered into between a licensee and the board.

23.1(12) Violation of an initial agreement or health contract entered into with the Iowa physician health program (IPHP).

23.1(13) Failure to comply with an evaluation order. Failure to comply with an order of the board requiring a licensee to submit to evaluation under Iowa Code section 148.6(2) "h" or 272C.9(1).

23.1(14) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of a profession includes, but is not limited to, an intentional perversion of the truth, either orally or in writing, by a physician in the practice of medicine and surgery or osteopathic medicine and surgery or by an acupuncturist.

23.1(15) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, an intentional perversion of the truth in making application for a license to practice acupuncture, medicine and surgery, or osteopathic medicine and surgery in this state, and includes false representations of material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a license in this state, or attempting to file or filing with the board any false or forged document submitted with an application for a license in this state.

23.1(16) Fraud in representations as to skill or ability. Fraud in representations as to skill or ability includes, but is not limited to, a licensee's having made misleading, deceptive or untrue representations as to the acupuncturist's or physician's competency to perform professional services for which the licensee is not qualified to perform by education, training or experience.

23.1(17) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making known to the public information or intention which is false, deceptive, misleading or promoted through fraud or misrepresentation and includes statements which may consist of, but are not limited to:

- a. Inflated or unjustified claims which lead to expectations of favorable results;
- b. Self-laudatory claims that imply that the licensee is skilled in a field or specialty of practice for which the licensee is not qualified;
- c. Representations that are likely to cause the average person to misunderstand; or

- d.* Extravagant claims or claims of extraordinary skills not recognized by the medical profession.
- 23.1(18)** Obtaining any fee by fraud or misrepresentation.
- 23.1(19)** Acceptance of remuneration for referral of a patient to other health professionals in violation of the law or medical ethics.
- 23.1(20)** Knowingly submitting a false report of continuing education or failure to submit the required reports of continuing education.
- 23.1(21)** Knowingly aiding, assisting, procuring, or advising a person in the unlawful practice of acupuncture, medicine and surgery, or osteopathic medicine and surgery.
- 23.1(22)** Failure to report disciplinary action. Failure to report a license revocation, suspension or other disciplinary action taken against the licensee by a professional licensing authority of another state, an agency of the United States government, or any country, territory or other jurisdiction within 30 days of the final action by such licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, such report shall be expunged from the records of the board.
- 23.1(23)** Failure to report voluntary agreements. Failure to report any voluntary agreement to restrict the practice of acupuncture, medicine and surgery, or osteopathic medicine and surgery entered into with this state, another state, the United States, an agency of the federal government, or any country, territory or other jurisdiction.
- 23.1(24)** Failure to notify the board within 30 days after occurrence of any settlement or adverse judgment of a malpractice claim or action.
- 23.1(25)** Failure to file the reports required by 653—22.2(272C) within 30 days concerning wrongful acts or omissions committed by another licensee.
- 23.1(26)** Failure to comply with a valid subpoena issued by the board pursuant to Iowa Code sections 17A.13 and 272C.6 and 653—subrule 24.2(6) and rule 653—25.12(17A).
- 23.1(27)** Failure to submit to a board-ordered mental, physical, clinical competency, or substance abuse evaluation or drug or alcohol screening.
- 23.1(28)** The inappropriate use of a rubber stamp to affix a signature to a prescription. A person who is unable, due to a disability, to make a written signature or mark, however, may substitute in lieu of a signature a rubber stamp which is adopted by the disabled person for all purposes requiring a signature and which is affixed by the disabled person or affixed by another person upon the request of the disabled person and in the presence of the disabled person.
- 23.1(29)** Maintaining any presigned prescription which is intended to be completed and issued at a later time.
- 23.1(30)** Failure to comply with the recommendations issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures, or with the protocols established pursuant to Iowa Code chapter 139A.
- 23.1(31)** Failure by a physician with HIV or HBV who practices in a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by a hospital under Iowa Code section 139A.22(1) or to an expert review panel established by the department of public health under Iowa Code section 139A.22(3).
- 23.1(32)** Failure by a physician with HIV or HBV who practices outside a hospital setting, and who performs exposure-prone procedures, to report the physician's HIV or HBV status to an expert review panel established by the department of public health under Iowa Code section 139A.22(3).
- 23.1(33)** Failure by a physician subject to the reporting requirements of 23.1(31) and 23.1(32) to comply with the recommendations of an expert review panel established by the department of public health pursuant to Iowa Code section 139A.22(3), with hospital protocols established pursuant to Iowa Code section 139A.22(1), or with health care facility procedures established pursuant to Iowa Code section 139A.22(2).
- 23.1(34)** Noncompliance with a support order or with a written agreement for payment of support as evidenced by a certificate of noncompliance issued pursuant to Iowa Code chapter 252J. Disciplinary

proceedings initiated under this rule shall follow the procedures set forth in Iowa Code chapter 252J and 653—Chapter 15.

23.1(35) Rescinded IAB 3/11/20, effective 4/15/20.

23.1(36) Improper management of medical records. Improper management of medical records includes, but is not limited to, failure to maintain timely, accurate, and complete medical records.

23.1(37) Failure to transfer medical records to another physician in a timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient.

23.1(38) Failure to respond to or comply with a board investigation initiated pursuant to Iowa Code section 272C.3 and 653—24.2(17A,147,148,272C).

23.1(39) Failure to comply with the direct billing requirements for anatomic pathology services established in Iowa Code Supplement section 147.106.

23.1(40) Failure to submit an additional completed fingerprint card and applicable fee, within 30 days of a request made by board staff, when a previous fingerprint submission has been determined to be unacceptable.

23.1(41) Failure to respond to the board or submit continuing education materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(42) Failure to respond to the board or submit requested mandatory training for identifying and reporting abuse materials during a board audit, within 30 days of a request made by board staff or within the extension of time if one had been granted.

23.1(43) Nonpayment of state debt as evidenced by a certificate of noncompliance issued pursuant to 2008 Iowa Acts, Senate File 2428, division II, and 653—Chapter 12.

23.1(44) Voluntary agreements. The board may take disciplinary action against a physician if that physician has entered into a voluntary agreement to restrict the practice of medicine in another state, district, territory, or country.

a. The board will use the following criteria to determine if a physician has entered into a voluntary agreement within the meaning of Iowa Code section 148.12 and this rule.

(1) The voluntary agreement was signed during or at the conclusion of a disciplinary investigation, or to prevent a matter from proceeding to a disciplinary investigation.

(2) The agreement includes any or all of the following:

1. Education or testing that is beyond the jurisdiction's usual requirement for a license or license renewal.

2. An assignment beyond what is required for license renewal or regular practice, e.g., adoption of a protocol, use of a chaperone, completion of specified continuing education, or completion of a writing assignment.

3. A prohibition or limitation on practice privileges, e.g., a restriction on prescribing or administering controlled substances.

4. Compliance with an educational plan.

5. A requirement that surveys or reviews of patients or patient records be conducted.

6. A practice monitoring requirement.

7. A special notification requirement for a change of address.

8. Payment that is not routinely required of all physicians in that jurisdiction, such as a civil penalty, fine, or reimbursement of any expenses.

9. Any other activity or requirements imposed by the board that are beyond the usual licensure requirements for obtaining, renewing, or reinstating a license in that jurisdiction.

b. A certified copy of the voluntary agreement shall be considered prima facie evidence.

23.1(45) Performing or attempting to perform any surgical or invasive procedure on the wrong patient or at the wrong anatomical site or performing the wrong surgical procedure on a patient.

23.1(46) Violation of the standards of practice for medical directors who delegate and supervise medical aesthetic services performed by nonphysician persons at a medical spa as set out at rule 653—13.8(148,272C).

23.1(47) Failure to provide the board, within 14 days of a request by the board as set out at 653—paragraph 13.8(5) “l,” written verification of the education and training of all nonphysician persons who perform medical aesthetic services at a medical spa.

23.1(48) Failure to file with the board a written report and a copy of the hospital disciplinary action within 30 days of any hospital disciplinary action or the licensee’s voluntary action to avoid a hospital investigation or hospital disciplinary action, as required by rule 653—22.5(272C).

This rule is intended to implement Iowa Code chapters 17A, 147, 148 and 272C and 2008 Iowa Acts, Senate File 2428, division II.

[ARC 8525B, IAB 2/10/10, effective 3/17/10; ARC 9088B, IAB 9/22/10, effective 10/27/10; ARC 9598B, IAB 7/13/11, effective 8/17/11; ARC 0533C, IAB 12/26/12, effective 1/30/13; ARC 4979C, IAB 3/11/20, effective 4/15/20]

653—23.2(272C) Student loan default or delinquency—prohibited grounds for discipline. The board shall not suspend or revoke a license issued by the board to a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

This rule is intended to implement Iowa Code section 272C.4(10).

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◊ Two or more ARCs

¹ Effective date of subrule 135.204(10) [renumbered 12/4(10), IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from November 2, 1983.

² Effective date of rules 135.206, 135.207 and 135.208 [renumbered 12.6, 12.7 and 12.8, IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from December 12, 1984. Delay lifted by committee on January 9, 1985.

TELECOMMUNICATIONS AND TECHNOLOGY COMMISSION, IOWA[751]

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CHAPTER 1
DESCRIPTION OF ORGANIZATION

751—1.1(17A,8D) Purpose. The Iowa telecommunications and technology commission and the Iowa communications network were established by Iowa Code chapter 8D to coordinate communications of state government, effect maximum practical consolidation and joint use of communications services and manage, develop, operate and ensure compatibility of the fiberoptic network.

751—1.2(17A,8D) Organization. The commission's structure consists of five commissioners and the state auditor as an ex officio member of the commission. The commission has the sole authority to manage, develop, operate and ensure compatibility of the state communications network. The network is supervised by the commission and operated by the executive director of the network or the commission's designee. The commission has rule-making authority.

751—1.3(17A,8D) Advisory committees. The commission may establish or dissolve committees and advisory groups from time to time as necessary.
[ARC 9600B, IAB 7/13/11, effective 8/17/11]

751—1.4(17A,8D) Education telecommunications council. Rescinded ARC 4983C, IAB 3/11/20, effective 4/15/20.

751—1.5(17A,8D) Administrative elements of the commission.

1.5(1) Executive director. The executive director or the commission's designee administers the programs and services of the commission in compliance with the Iowa Code and the rules adopted by the commission. The executive director's office is responsible for providing legislative liaison and public information functions, as well as providing administrative support to the commission. The executive director's office provides information and education to the public about the commission and the fiberoptic network and maintains the commission's Web site.

1.5(2) Administrative elements. In order to carry out the functions of the commission, the following divisions have been established:

a. The administrative division coordinates the activities between the engineers, individual sites, and authorized users. The division is responsible for providing cost estimates for services; tracking service requests; executing installation services; assisting authorized users in finding the best structure to meet the users' needs; developing new products and services; maintaining price tables; and providing customer service and assistance. The division is also responsible for maintaining the financial books and records of the commission, accounting, billing, asset inventory and management, personnel transactions, travel vouchers, claims for payments of goods and services, processing cash receipts, purchasing, and contracting activities, as well as coordination with the attorney general's office for legal counsel.

b. The network operations and engineering division is responsible for provisioning of video services, data/Internet services, and voice services for authorized users. The division is responsible for all operational aspects of the fiberoptic network. The division is responsible for the technical operation of the fiberoptic network, including research and development; network systems; agency information systems functions; and maintenance of a circuit database.

[ARC 9148B, IAB 10/6/10, effective 11/10/10; ARC 9600B, IAB 7/13/11, effective 8/17/11; ARC 0409C, IAB 10/17/12, effective 11/21/12]

751—1.6(17A,8D) Location of offices.

1.6(1) Main office. The main office is located in the Grimes State Office Building, 400 E. 14th Street, Des Moines, Iowa 50319. The telephone number is (515)725-4692. The toll-free number is 1-877-426-4692. The fax number is (515)725-4727. The E-mail address is ICN.info@iowa.gov. The home page address on the World Wide Web is <http://www.icn.state.ia.us>.

1.6(2) Network. The hub for the network is located in the Joint Forces Headquarters (JFHQ) Armory, 6100 N.W. 78th Avenue, Johnston, Iowa 50131.

751—1.7(8D) Business hours.

1.7(1) *Normal business hours.* The normal business hours of the main office are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. The Network Operations Center (NOC) operates on a 24-hour, seven-day-a-week basis at the network hub in the JFHQ Armory in Johnston, Iowa.

1.7(2) *Emergency incident reports.* The 24-hour emergency telephone number for reporting cable cuts, system failures or other incidents is 1-800-572-3940, or (515)323-4400.

These rules are intended to implement Iowa Code sections 17A.3(1)“a,”8D.1, 8D.3(3)“b,”8D.5 and 8D.6.

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CHAPTER 8
SCHEDULING DISPUTES
Rescinded **ARC 4983C**, IAB 3/11/20, effective 4/15/20

CHAPTER 15
ADVISORY COUNCILS, COMMITTEES
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751—15.1(8D) Meetings for advisory councils, committees and groups. Any advisory councils, committees or groups established by Iowa Code chapter 8D or at the direction of the commission must meet at least twice annually. If any of these groups fail to meet and advise or provide recommendations to the commission, the commission may appoint new members to the advisory councils, committees or groups or as otherwise provided by law.

751—15.2(8D) Attendance by members. Each advisory council shall establish attendance policies for its members subject to approval by the commission. In the event the commission, through the recommendations of an advisory council, a committee or group, removes a member from an advisory council, a committee or group, the commission may replace that member immediately.

751—15.3(8D) Duties of advisory councils, committees and groups. The advisory councils, committees and groups at a minimum shall have the following duties:

15.3(1) Develop rules. Develop proposed rules for commission consideration regarding use of and access to the network. The commission may refuse to approve and adopt a proposed rule, and upon such refusal, shall return the proposed rule to the advisory group proposing the rule with a statement indicating the commission's reason for refusing to approve and adopt the rule.

15.3(2) Prepare reports. As requested from time to time by the commission, provide information, reports and perform special projects to assist the commission in completing its mission.

15.3(3) Provide notices of meetings and minutes of meetings.

a. Each advisory council, committee or group shall prepare minutes of its meetings and submit the minutes to the commission within 60 days of the date of the meeting for posting on the Iowa communications network Web site.

b. Each advisory council, committee or group shall provide notice of its meetings to interested parties identified by the commission or the advisory council, committee or group. An advisory council, committee or group shall submit an electronic agenda and notice to the ICN one week prior to a scheduled meeting for posting on the Iowa communications network Web site.

15.3(4) Develop mission statement. Each advisory council, committee or group shall prepare a written mission statement. The mission statements shall be filed with the commission.

15.3(5) Scheduling and site usage policies. Subject to approval by the commission, the advisory councils, committees and groups shall establish site and usage policies for authorized users of the network.

[ARC 0409C, IAB 10/17/12, effective 11/21/12]

751—15.4(8D) Additional duties of education telecommunications council. Rescinded ARC 4983C, IAB 3/11/20, effective 4/15/20.

751—15.5(8D) Additional duties of regional educational telecommunications council. Rescinded ARC 4983C, IAB 3/11/20, effective 4/15/20.

This chapter is intended to implement Iowa Code sections 8D.3, 8D.5, 8D.6, and 8D.7.

[Filed 3/21/97, Notice 1/15/97—published 4/9/97, effective 5/14/97]

[Filed ARC 0409C (Notice ARC 0269C, IAB 8/8/12), IAB 10/17/12, effective 11/21/12]

[Filed ARC 4983C (Notice ARC 4626C, IAB 8/28/19), IAB 3/11/20, effective 4/15/20]

TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 117
OUTDOOR ADVERTISING

[Prior to 6/3/87, Transportation Department[820]—(06,O) Ch 5]

761—117.1(306B,306C) Definitions. The definitions in Iowa Code section 306C.10 are adopted. In addition:

“Abandoned sign” means an advertising device for which the owner has failed to timely apply for the required outdoor advertising permit(s) or has failed to timely pay the required fee(s).

“Area zoned and used for commercial or industrial purposes” means an area zoned for commercial or industrial purposes in accordance with Iowa Code chapter 414, in the case of city zoning, or in accordance with Iowa Code chapter 335, in the case of county zoning, in which one or more commercial or industrial activities, as defined under the city or county zoning ordinance, are located.

“Billboard control Act” means Iowa Code chapter 306C, division II.

“Bonus Act” means Iowa Code chapter 306B.

“Daylight area” means a triangular area formed by a line connecting two points each back (50 feet in city, 100 feet in unincorporated area) from the point where the right-of-way lines of the main traveled way and an intersecting street meet or would meet if extended.

“Destroyed” means that at least 60 percent of the supports are broken, if wooden, or broken, bent or twisted, if metal, such that normal repair practices would call for the replacement of the damaged supports.

“Development directory sign” means the same as defined in rule 761—117.15(306C).

“Directional and official signs and notices” means official signs and notices, public utility signs, service club and religious notices, public service signs, and directional signs.

“Directional sign” means a sign governed by 761—Chapter 120.

“Face” means that part of an advertising device that is devoted to the display of advertising and that is visible to traffic proceeding in any one direction.

“Interchange” means the entire area constructed for a junction of two or more public streets or highways by a system of separate levels that permit traffic to pass from one level to another without the crossing of traffic streams. This includes all acceleration and deceleration lanes constructed to accommodate this movement of traffic.

“Lease” means an agreement, oral or written, by which possession or use of land or interests therein are given by the owner or other person to another person for a specified purpose.

“LED display” means a face, as defined herein, displaying a message that is formed by light emitting diodes and that is changed by an electronic process. An LED display is a single face.

“Modification” means any addition to or change in dimensions, lighting, structure or advertising face, except as incidental to the customary maintenance of an advertising device.

1. A change in the number or type of support posts is a modification. A change in dimensions is a modification. However, the addition of extensions or cutouts, including forward projecting, is not a modification if the extensions or cutouts are added for a period of 90 days or less and if they are illuminated only by existing sign lighting and do not contain internal lighting.

2. A lawful change in advertising message is not a modification. The use of a vinyl overlay or wrap on either a poster panel or paint unit is a change in advertising message, not a modification.

3. On an advertising device that conforms to all current requirements, the replacement of one metal-framed face with another metal-framed face of the same size, using dissimilar component parts or assembly methods, or both, is not a modification.

4. The addition of LED display capabilities to an advertising device is a modification.

5. The elimination of trim surrounding the area used for advertising copy is not a modification, provided the advertising copy retains the same dimensions as the original advertising copy.

“Nonconforming sign” means an advertising device that was lawfully erected and continues to be lawfully maintained, but that does not comply with current requirements due to changed conditions, such as a change in zoning, establishment of a new highway, or a similar change that affects compliance.

“Obsolete sign” means an advertising device displaying information pertaining to activities that are no longer conducted or products or services that are no longer available at the advertised location.

“Official sign or notice” means a sign or notice lawfully erected and maintained by a city, county or public agency within its territorial or zoning jurisdiction for the purpose of carrying out an official duty or responsibility.

“On-premises sign” or *“on-property sign”* means an advertising device advertising the sale or lease of, or activities being conducted upon, the property where the sign is located. The criteria to be used to determine if an advertising device qualifies as on-premises signing, excluding development directory signing, include but are not limited to the following:

1. A sign that consists solely of the name of the establishment or that identifies the establishment’s principal or accessory products or services offered on the property is an on-premises sign.

2. An on-premises sign must be located on the same property as the advertised activity or the same property as that advertised for sale or lease. A subdivided property may be considered to be one property if all lots remain under common ownership and all lots share a common, private access to public roads. However, if any lot in the subdivided property is sold or disposed of in any manner, that lot will be considered to be separate property.

3. Contiguous lots or parcels of land may be considered to be one property for outdoor advertising control purposes provided they are owned or leased by the same party. To be considered one property, all contiguous lots or parcels of land must also be used for a purpose related to the advertised activity other than signing.

4. An on-premises sign shall not be located on a narrow strip of land that cannot reasonably be used for a purpose related to the advertised activity other than signing.

5. An on-premises sign is limited to advertising the property’s sale or lease, or identifying the activities located on or products or services available on the property.

6. An advertising device is not an on-premises sign if it consists principally of brand- or trade-name advertising and either the product or service advertised is only incidental to the establishment’s principal products or services or the advertising brings rental income to the property owner. “Principally” means 50 percent or more of the display area of the sign.

7. An on-premises sign concerning the sale or lease of property shall not display the legend “sold” or “leased” or a similar message.

“Public utility sign” means a warning or informational sign, notice or marker that is customarily erected and maintained by a publicly or privately owned utility to mark the location of a utility facility.

“Regularly used” means open for business and staffed by an owner or employee for at least 20 hours per week, on property assessed as commercial or industrial by the jurisdiction having authority; the hours of operation must be visibly posted on the premises. The department may delay action on the permit application for up to 180 days from the date of the application in order to conduct periodic checks on the site as necessary to determine whether the purported commercial or industrial activity meets this definition. A rental storage business is excepted from the staffing requirement if it has 24-hour access for customers and a minimum of 50 units, each occupying at least 50 square feet, individually separated, and enclosed by walls.

“Scenic area” means any area of particular scenic beauty or historical significance, as determined by the federal, state or local officials having jurisdiction of the area. It includes real property interests that have been acquired for the restoration, preservation and enhancement of scenic beauty.

“Service club or religious notice” means a sign displaying a message that is limited to the name of a nonprofit service club, charitable association, church or religious group or cemetery, the location and hours of its meetings or services or the hours it is open to the public, and an appropriate emblem.

“Tri-face device” means an advertising device with three singular faces attached to one common structure in a triangular configuration. The maximum area of any face is 750 square feet. The inside angle formed by any two faces may not exceed 60 degrees.

“Tri-vision device” means an advertising device that has an advertising face with a mechanical device that allows three advertising messages to be alternately visible to traffic proceeding in any one

direction. Each message is attached to individual vertical or horizontal louvers, which are mechanically rotated to change the message.

“*Widening*” means the point at which it is detectable that a deceleration or exit ramp is beginning to form alongside the main traveled way, or an acceleration or merging ramp has tapered to a close alongside the main traveled way. In the case where an entrance ramp becomes an auxiliary lane and the auxiliary lane becomes an exit ramp at the adjacent interchange, the widening shall be the point at which a deceleration ramp completely separates from the main traveled way as evidenced by the inside lane marking of such ramp, or an acceleration ramp joins with the main traveled way as evidenced by the inside lane marking of the ramp intersecting with the outside lane marking of the main traveled way.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.2(306B,306C) General provisions.

117.2(1) Scope. This chapter of rules pertains to all advertising devices which are visible from the main traveled way of any primary highway, with the following exceptions:

a. Within incorporated areas, this chapter does not apply to advertising devices which are beyond 660 feet from the nearest edge of the right-of-way.

b. Except where specified otherwise, this chapter does not apply to official traffic control devices, logo signing, tourist-oriented directional signing, or private directional signing.

117.2(2) Contact information. Inquiries, requests for forms, and applications regarding this chapter shall be directed to the Advertising Management Section, Traffic and Safety Bureau, Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

117.2(3) Unauthorized signs, signals, or markings. Any sign, signal, marking or device prohibited by Iowa Code section 321.259 is a public nuisance and shall be removed by the department if it is within the department’s jurisdiction.

117.2(4) Advertising devices obstructing the view of a highway or railway. Any advertising device that obstructs the view of any portion of a public highway or railway track in violation of Iowa Code subsection 318.11(2) or 657.2(7) is a public nuisance, which shall be abated as provided in Iowa Code chapter 657.

117.2(5) Advertising devices within the right-of-way. Any advertising device placed or erected within the right-of-way of any primary highway in violation of Iowa Code chapter 318 is subject to removal in the manner specified in Iowa Code chapter 318.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.3(306B,306C,306D) General criteria. The department shall control the erection and maintenance of advertising devices, subject to the provisions of these rules, in accord with the following criteria:

117.3(1) Prohibition. Advertising devices shall not be erected, maintained or illuminated unless they comply with the following:

a. No advertising device shall attempt or appear to attempt to direct the movement of traffic.

b. No advertising device shall interfere with, imitate or resemble any official sign, signal or device.

c. No advertising device subject to the more restrictive controls of the bonus Act shall move or have any animated or moving parts.

d. No advertising device shall be erected or maintained upon trees, painted or drawn upon rocks or other natural features.

e. No off-premises advertising device shall include any flashing, intermittent or moving light or lights except those signs giving public service information such as time, date, temperature, weather and news. No on-premises sign located within the adjacent area of an interstate highway but outside an area zoned and used for commercial or industrial purposes, as defined in rule 761—117.1(306B,306C), shall include any flashing, intermittent or moving light or lights except those signs giving public service information such as time, date, temperature, weather and news. Any variation or addition to the stated service information is subject to department approval. This paragraph does not prohibit an LED display, provided:

(1) Each change of message is accomplished in one second or less.

- (2) Each message remains in a fixed position for at least eight seconds.
- (3) No traveling messages (e.g., moving messages, animated messages, full-motion video, scrolling text messages) or segmented messages are presented.

f. No lighting shall be used in any way in connection with any advertising device unless it is so effectively shielded as to prevent beams or rays of light from being directed at any portion of the main traveled way of any highway, or is of such low intensity or brilliance as to not cause glare or to impair the vision of the driver of any motor vehicle, or to otherwise interfere with any driver's operation of a motor vehicle. This paragraph does not prohibit an LED display provided the light intensity presented does not exceed that allowed for other illuminated displays.

g. No advertising device subject to the more restrictive controls of the bonus Act shall be obsolete.

h. No advertising device shall be in a state of disrepair or illegible for a period of time exceeding 90 days.

i. Advertising devices shall be securely affixed to a substantial structure.

j. No advertising device subject to the more restrictive controls of the bonus Act shall advertise activities which are illegal under federal or state laws in effect at the location of those activities or at the location of the sign.

k. An advertising device shall comply with all applicable state and local laws, regulations and ordinances, including but not limited to zoning, building and sign codes as locally interpreted and applied and enforced, which may be stricter than this chapter.

l. No off-premises advertising device may be erected within the adjacent area of any primary highway that has been designated a scenic highway or scenic byway if the advertising device will be visible from the highway. However, if the off-premises advertising device was in existence at the time of the designation, subsequent permitting may occur in accordance with Iowa Code section 306C.18.

m. An advertising device shall not be constructed or reconstructed beyond the adjacent area in unincorporated areas of the state if the advertising device is visible from the main traveled way of any primary highway except for on-premises signs and official signs and notices.

117.3(2) *Measurements of distance.* Distance from the edge of a right-of-way shall be measured horizontally along a line normal or perpendicular to the centerline of the highway. All other measurements of distance shall be measured horizontally between points on a line parallel to the highway centerline.

117.3(3) *Measurement of area.* The area of an advertising device shall be measured by the smallest square, rectangle, triangle, circle or combination thereof which will encompass the entire display area including border and trim, but excluding temporary cutouts and extensions, base, apron, support, and other structural members.

117.3(4) *Zoning exclusions.*

a. A zone in which limited commercial or industrial activities are permitted incidental to other primary land uses is not a commercial or industrial zone for advertising control purposes.

b. Action which is not a part of comprehensive zoning in accordance with Iowa Code chapter 335 or Iowa Code chapter 414 is not a commercial or industrial zone for advertising control purposes.

c. Action taken primarily to permit advertising devices is not a commercial or industrial zone for advertising control purposes.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.4(306B,306C) Interstate special provisions for on-premises signs. This rule applies to on-premises signs located within the adjacent area of any interstate highway, except those areas exempt from control under Iowa Code section 306B.2(4).

117.4(1) *Interstate on-premises signs (restricted).* Within the adjacent area of any interstate highway not more than one on-premises sign, visible to traffic proceeding in any one direction on any one interstate highway, advertising activities conducted upon the real property where the sign is located, may be erected or maintained more than 50 feet from the advertised activity. Such on-premises signs more than said 50 feet shall be subject to the permit provisions of rule 117.6(306C).

117.4(2) Interstate on-premises signs (for sale or lease). Within the adjacent area of any interstate highway, not more than one on-premises sign advertising the sale or lease of the same property upon which the sign is located may be permitted in such a manner as to be visible to traffic proceeding in any one direction on any one interstate highway.

117.4(3) Interstate on-premises size limitations. An on-premises sign within the adjacent area of an interstate shall be no larger than 20 feet in length, width or height and 150 square feet in area. However, an on-premises sign advertising activities conducted within 50 feet of the sign is exempt from these size limitations. This exemption does not apply to a sign advertising the sale or lease of property where the sign is located.

117.4(4) Interstate on-premises signs (unrestricted). Within the adjacent area of any interstate highway, on-premises signs advertising activities conducted within 50 feet of the sign, located upon the same real property where the sign is located, are not subject to regulations as to number of signs, size, or spacing; however, for the purpose of determining the 50-foot distance, the limits of the advertised activity shall be determined as follows:

a. When the advertised activity is a business, commercial or industrial land use, the distance shall be measured from the regularly used buildings, parking lots, storage or processing areas or other structures which are essential and customary to the conduct of the business.

b. When the advertised activity is a noncommercial or nonindustrial land use such as a residence, farm, or orchard, the distance shall be measured from the major structures or areas used in furtherance of the advertised activities.

117.4(5) Interstate advertising devices not subject to control until July 1, 1972. Rescinded IAB 8/4/04, effective 9/8/04.

761—117.5(306B,306C) Location, size and spacing requirements. This rule does not apply to on-premises signs.

117.5(1) Advertising devices lawfully in existence prior to July 1, 1972.

a. An advertising device that was lawfully in existence prior to July 1, 1972, and is visible from any primary highway, including a device located beyond the adjacent area in unincorporated areas, may remain in existence without conforming to subrule 117.5(5) as long as the device otherwise conforms to all other applicable statutory and regulatory requirements. The permit provisions of rule 761—117.6(306C) apply.

b. If the advertising device is located in an adjacent area which is neither a zoned nor an unzoned commercial or industrial area, the device may remain in existence as described in paragraph “a” of this subrule only until such time as the device is acquired by the department. The permit issued for the device will be a provisional permit. See subrule 117.6(3) and rule 761—117.9(306B,306C).

117.5(2) Advertising devices lawfully in existence prior to July 1, 1972, beyond 660 feet from the right-of-way. Rescinded IAB 11/27/02, effective 1/1/03.

117.5(3) Abandoned signs. Abandoned signs which do not comply with these rules shall be removed by the department without compensation regardless of when erected.

117.5(4) Advertising devices lawfully in existence prior to July 1, 1972, within adjacent areas neither zoned nor unzoned commercial or industrial. Rescinded IAB 11/27/02, effective 1/1/03.

117.5(5) Advertising devices erected after July 1, 1972. Except as otherwise provided in this chapter, an advertising device which is visible from the main traveled way of any primary highway shall not be erected after July 1, 1972, or subsequently maintained within the adjacent area unless the advertising device complies with the following:

a. Permit required. A current permit from the department is required for the erection or subsequent maintenance of the advertising device.

b. Commercial or industrial area.

(1) An advertising device visible from the main traveled way of an interstate highway must be located within an area zoned and used for commercial or industrial purposes, as defined in rule 761—117.1(306B,306C); within 750 feet of the regularly used portion of a commercial or industrial activity visible from the main traveled way; and on the same, individual, platted parcel of land as that

commercial or industrial activity. The commercial or industrial activity must be one defined under the city's or county's, as applicable, zoning ordinance.

(2) An advertising device visible from the main traveled way of a noninterstate primary highway must be located within a commercial or industrial zone or an unzoned commercial or industrial area, as defined in Iowa Code section 306C.10.

c. Spacing within city—interstate and freeway-primary highway. Within the corporate limits of a municipality, the following provisions apply to an advertising device which is visible from an interstate or a freeway-primary highway:

(1) The advertising device shall not be located within 250 feet of another advertising device when both are visible to traffic proceeding in any one direction.

(2) The advertising device shall not be located within the adjacent area on either side of the highway in, or within 250 feet of an interchange or rest area. The 250 feet shall be measured from the nearest point of widening for a lane constructed for the purpose of acceleration or deceleration of traffic movement to or from the main traveled way to the advertising device. The measurement shall be taken parallel to the centerline of the main traveled way and shall be taken from whichever point of widening extends the furthest from the interchange.

d. Spacing outside city—interstate and freeway-primary highway. Outside the corporate limits of a municipality, the following provisions apply to an advertising device which is visible from an interstate or a freeway-primary highway:

(1) The advertising device shall not be located within 500 feet of another advertising device when both are visible to traffic proceeding in any one direction.

(2) The advertising device shall not be located within the adjacent area on either side of the highway in, or within 250 feet of an interchange or rest area. The 250 feet shall be measured from the nearest point of widening for a lane constructed for the purpose of acceleration or deceleration of traffic movement to or from the main traveled way to the advertising device. The measurement shall be taken parallel to the centerline of the main traveled way and shall be taken from whichever point of widening extends the furthest from the interchange.

e. Spacing within city—nonfreeway-primary highway. Within the corporate limits of a municipality, the following provisions apply to an advertising device which is visible from a nonfreeway-primary highway:

(1) The advertising device shall not be located within 100 feet of another advertising device when both are visible to traffic proceeding in any one direction.

(2) The advertising device shall not be located within the daylight area. However, if a building is located within the daylight area, a wall advertising device may be attached to the building provided the device does not protrude more than 12 inches, exclusive of catwalk and lights. No part of a catwalk or lights may overhang the right-of-way. The permit for the advertising device shall be revoked if the building the device is attached to is removed.

f. Spacing outside city—nonfreeway-primary highway. Outside the corporate limits of a municipality, the following provisions apply to an advertising device which is visible from a nonfreeway-primary highway:

(1) The advertising device shall not be located within 300 feet of another advertising device when both are visible to traffic proceeding in any one direction.

(2) The advertising device shall not be located within the daylight area. However, if a building is located within the daylight area, a wall advertising device may be attached to the building provided the device does not protrude more than 12 inches exclusive of catwalk and lights. No part of a catwalk or lights may overhang the right-of-way. The permit for the advertising device shall be revoked if the building the device is attached to is removed.

g. Spacing—signs separated by a building. The distance and spacing requirements of subparagraphs “c”(1), “d”(1), “e”(1), and “f”(1), above, shall not apply to advertising devices which are separated by a building in such a manner that only one advertising device located within the minimum spacing distance is visible from a highway at any one time.

h. Spacing—measurement of distance. The minimum distance between two advertising devices visible to traffic proceeding in the same direction shall apply without regard to the side of the highway on which the advertising devices may be located and shall be measured along a line parallel to the centerline of the highway between points directly opposite the advertising devices. When a sign is visible and subject to control from more than one primary highway, it must meet spacing requirements along each route.

i. Spacing—rural area next to incorporated area.

(1) In a rural area next to an incorporated area, the first rural sign placement shall be no closer than the rural spacing requirement measured from the point where the corporation line intersects the centerline or from the point where a line normal or perpendicular to the centerline of the highway intersects the first unincorporated area within the adjacent area to a point directly opposite the first potential sign location.

(2) In those areas where the adjacent area on one side of the highway is incorporated and on the opposite side of the highway all or part of the adjacent area is not, the spacing on both sides of the highway, except for daylight spacing, shall be regulated by the rural or unincorporated area spacing requirements.

j. Signs not considered when determining spacing. Directional and other official signs and notices and on-premises advertising devices shall not be taken into consideration in determining compliance with spacing requirements.

k. Sizes and types. Only the following types of advertising devices are permitted: single-face, side-by-side, double-deck, tri-vision, back-to-back, v-type, and tri-face.

(1) The multiple faces or panels of an advertising device must be contiguous or on a common structure. Side-by-side configurations are contiguous if the faces are not more than two feet apart and they are owned by the same permit holder. Side-by-side configurations must be on the same vertical and horizontal planes.

(2) A maximum of one face of an advertising device may be visible to traffic proceeding in any one direction. An advertising device other than a tri-face device may have no more than two faces.

(3) For an advertising device with one face, the maximum display area of the face is 1200 square feet. This applies to single-face, side-by-side, double-deck and tri-vision devices. For permit purposes, side-by-side and double-deck configurations are considered one face with the surface areas combined into one square footage.

(4) For an advertising device with two or more faces, the maximum display area of each face is 750 square feet. This applies to back-to-back and v-type devices (which have two faces) and tri-face devices (which have three faces).

(5) Each message on a tri-vision device must be displayed for a minimum of four seconds and the transition between messages must be completed in two seconds.

l. Spacing—transition to freeway-primary highway. As a segment of a noninterstate primary highway changes to a freeway-primary highway, the first freeway-primary highway sign placement shall be no closer than the freeway-primary highway spacing requirements measured along a line parallel to the centerline from a point opposite the point where the centerline of the highway and centerline of the at-grade crossing intersect to a point opposite the first potential sign location. See the appendix for an illustration of this spacing requirement.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.6(306C) Outdoor advertising permits and fees required. The owner of an advertising device must apply to the department for an outdoor advertising permit if the device is visible from the main traveled way of any primary highway and the device is regulated by subrule 117.4(1) or rule 761—117.5(306B,306C).

1. If an advertising device was in existence on July 1, 1972, application for a permit must have been made on or before July 31, 1972.

2. After July 1, 1972, the owner of an advertising device must obtain a permit from the department prior to the erection of the advertising device.

3. If an advertising device that was lawfully erected later becomes subject to these rules due to an event such as, but not limited to, a change in zoning, the establishment of a new highway or a change in the designation of a highway, the owner of the advertising device shall apply to the department for an outdoor advertising permit within 30 days after the event that made the device nonconforming. A nonconforming advertising device that complies with the permit provisions of rule 117.6(306C) may remain in existence without being in compliance with subrule 117.5(5) as long as the device otherwise complies with all other applicable statutory and regulatory requirements.

117.6(1) Application. Application for a permit shall be made in accordance with Iowa Code section 306C.18.

a. A permit is required for each face of an advertising device; thus, a permit application must be submitted for each face. Three permits are required for a tri-face device if all three faces are visible from the main traveled way of a primary highway.

b. A copy of the current lease shall be submitted upon application for a permit.

c. Any intentional falsification or misrepresentation of information in the application or renewal process shall result in immediate denial or revocation of the permit.

117.6(2) Fees. Fees are applicable to all advertising devices measuring over 32 square feet in size.

a. The initial fee, payable at the time of application, is \$100 per permit. This fee is not refundable unless the application is withdrawn prior to the department's field review of the proposed location.

b. The annual renewal fee for each permit, due on or before June 30 of each year, is as follows:

<u>Area of Sign</u>	<u>Annual Renewal Fee</u>
33 to 375 square feet	\$15
376 to 999 square feet	\$25
1000 square feet or more	\$50

For tri-vision signs, the area shall be calculated by multiplying the area of the face by three.

(1) The renewal fee is not refundable.

(2) Failure to timely pay the annual renewal fee when due shall result in revocation of any permit that has been issued for the advertising device and removal of the advertising device as an abandoned sign.

c. Fees shall not be prorated.

d. If an outdoor advertising permit is revoked, any permit fee paid is forfeited.

117.6(3) Permits to be issued.

a. The department shall issue an outdoor advertising permit in accordance with Iowa Code section 306C.18. Permits shall not be transferrable to other advertising devices or to other locations.

b. An advertising device that was lawfully in existence prior to July 1, 1972, and is located within an adjacent area which is neither a zoned nor an unzoned commercial or industrial area shall be issued a provisional permit and annual renewals thereof upon timely application and payment of the required fees, until such time as the department acquires the advertising device. See rule 761—117.9(306B,306C).

c. The department shall not prevent nor unnecessarily delay the issuance of a permit for the reason of a proposed future highway improvement project, except under any of the following conditions:

(1) The property upon which the advertising device is proposed has been appraised for the purposes of acquisition.

(2) Contact by department staff has been made with the property owner regarding compensation for the affected area.

(3) The placement of the advertising device would fail to meet the requirements of an existing corridor preservation plan in effect for the proposed location.

(4) A construction contract for the project has been initiated by the department.

117.6(4) Permit plate.

a. Upon approval of the application, the department shall issue a metal permit plate for the advertising face.

b. The owner of the advertising device shall securely attach the plate to the advertising face at the bottom corner nearest the main traveled way or to the support structure immediately below the bottom corner. If these locations do not permit unobscured display of the permit number, the permit plate shall be attached to another prominent area of the advertising device. The permit number shall not be obscured when viewed from the main traveled way.

c. The owner of an advertising device is responsible for replacing a permit plate that is missing or illegible. To obtain a replacement, the owner shall apply to the department and pay a \$10 fee.

d. If the department notifies the owner of the advertising device that a permit plate is not properly displayed, the owner shall within 90 days of notification either correct the situation or secure and display a replacement permit plate. Failure to properly display a permit plate after the 90-day period has expired shall result in revocation of any permit that has been issued for the advertising device and removal of the advertising device in the manner specified in subrule 117.8(1).

117.6(5) *New permit required for reconstruction or modification.* A new permit is required from the department prior to the reconstruction or modification of an advertising device subject to the permit provisions of this rule.

a. To obtain a new permit, the owner of the advertising device shall submit a new application to the department, accompanied by the initial application fee.

b. A reconstructed or modified advertising device is subject to the provisions of this chapter as if it were a new advertising device.

c. Reconstruction or modification of an advertising device prior to the issuance of the required permit shall result in revocation of any permit that has been issued for the advertising device and removal of the advertising device in the manner specified in subrule 117.8(1).

d. Rescinded IAB 4/7/99, effective 5/12/99.

117.6(6) *One year to erect advertising device.* The permit for an advertising device that has not been erected within one year after the date the permit was issued shall be revoked. After revocation, a new permit is required. To obtain a new permit, the owner of the advertising device shall submit a new application to the department, accompanied by the initial application fee and a copy of the current lease.

117.6(7) *Access.* Access to the private property upon which an advertising device is located shall be gained from highway right-of-way only at access points designated or allowed by the department in accordance with 761—Chapter 112. An initial violation of this requirement by or on behalf of the permit holder shall result in the department sending a written warning by certified mail to the permit holder. A second violation of this requirement shall result in revocation of any permit that has been issued for the advertising device and removal of the advertising device in the manner specified in subrule 117.8(1). If a permit is revoked for an access violation, the permit holder is ineligible to apply for a permit for at least 12 months after revocation for any location within 500 feet of the revoked permit's sign location.

117.6(8) *Destruction of vegetation.* Without the written authorization of the department, vegetation growing on the highway right-of-way shall not be cut, trimmed, removed, or in any manner altered or damaged to improve the visibility of an advertising device. Violation of this prohibition by or on behalf of the permit holder shall result in revocation of any permit that has been issued for the advertising device and removal of the advertising device in the manner specified in subrule 117.8(1). If a permit is revoked for destruction of vegetation, the permit holder is ineligible to apply for a permit for 12 months after revocation for any location within 500 feet of the revoked permit's sign location.

117.6(9) *Blank sign.*

a. A blank sign is:

(1) An advertising device that has had a face physically removed.

(2) An advertising device that does not display copy. "This space for rent" or a similar message is not copy.

(3) An advertising device that qualifies as an obsolete sign.

b. A blank sign shall not remain in blank status for a period of time exceeding six months.

c. If the department determines that an advertising device has been blank for a period of time exceeding six months, the department shall issue a notice pursuant to rule 761—117.8(306B,306C) in which the owner has 30 days to either cause it to conform or to remove it.

117.6(10) Destroyed sign.

a. The permit for an advertising device which has been destroyed shall be revoked.

b. An advertising device which has been destroyed is in a condition which, if repaired, would meet the definition of reconstruction in Iowa Code section 306C.10 and is subject to subrule 117.6(5).

c. An advertising device which has been damaged, but not destroyed, may be repaired. The repair shall not be deemed an act of reconstruction.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.7(306C) Official signs and notices, public utility signs, and service club and religious notices.

117.7(1) Official signs and notices. Official signs and notices shall comply with applicable state law, local ordinance or administrative authority.

117.7(2) Public utility signs. Public utility signs shall be erected no larger than required to adequately convey the necessary message and only at such places as are required to adequately mark the location of the utility.

117.7(3) Service club and religious notices. Service club and religious notices may be placed upon private property with the permission of the land owner provided the notice complies with the definition of “service club or religious notice” in rule 761—117.1(306B,306C), complies with the general criteria of rule 761—117.3(306B,306C,306D), and does not exceed eight square feet in area.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.8(306B,306C) Removal procedures. The department shall cause to be removed every advertising device illegally erected or maintained and every abandoned sign.

117.8(1) Removal of illegal and abandoned advertising devices. In accordance with Iowa Code sections 306B.5 and 306C.19, an advertising device erected or maintained in violation of Iowa Code chapter 306B or 306C or these rules is a public nuisance and may be removed by the department upon 30 days’ notice, by certified mail, to the owner of the advertising device and to the owner of the land on which the advertising device is located.

a. The notice shall require the owner of the advertising device to remove the advertising device if it is prohibited, or to cause it to conform to the provisions of these rules if it is not. The department may revoke a permit issued for the advertising device as part of the same notice, in which case, the notice shall be served by restricted certified mail or by personal service.

b. If the advertising device has not been removed or made to conform with the provisions of these rules, the advertising device is deemed to be forfeited and the department may enter upon the land and remove the advertising device, aided by injunction to abate the nuisance and to ensure peaceful entry, if necessary.

c. Costs of removal, including fees and costs or expenses as may arise out of any action brought by the department to ensure peaceful entry and removal, shall be assessed against the owner of the advertising device. Should the owner of the advertising device fail to pay such fees, costs, or expenses within 30 days after assessment, the department may commence an action to collect them.

d. The advertising device may be used, scrapped, dismantled, or otherwise destroyed or disposed of by the department as it sees fit.

e. No compensation shall be paid to the owner of any advertising device which is illegally erected or maintained.

117.8(2) Removal from right-of-way and other state-owned property. The department shall remove advertising devices erected upon the right-of-way of any primary highway; see subrule 117.2(5). Unauthorized advertising devices erected upon other property owned by the state of Iowa are subject to removal by the agency, board, commission or department having control or jurisdiction of the property.

[ARC 2645C, IAB 8/3/16, effective 9/7/16]

761—117.9(306B,306C) Acquisition of advertising devices that have been issued provisional permits.

117.9(1) The department will acquire an advertising device for which a provisional permit has been issued only if all of the following conditions are met:

- a. Acquisition is required by federal law.
- b. All necessary federal and state funding is available for the purpose.
- c. The permit has not been revoked.

117.9(2) If the advertising device will be acquired, the department will use the following procedure:

a. The department shall mail or deliver to the owner of the advertising device and to the owner of the land upon which the device is located a written notice of the department's intent to revoke the provisional permit and acquire the device. The notice shall include an offer to purchase the advertising device. If good-faith negotiations with the owner of the device and the owner of the land upon which the device is located do not result in a mutually agreeable sale price, the department shall revoke the provisional permit and initiate condemnation proceedings as provided in Iowa Code chapter 6B.

b. In the event of condemnation, the department will take possession of the advertising device as soon as the award has been deposited with the sheriff.

761—117.10(17A,306C) Contested cases.

117.10(1) An applicant who has been denied an outdoor advertising permit by the department may contest the decision in accordance with 761—Chapter 13. The request for a contested case hearing shall be submitted in writing to the director of the traffic and safety bureau at the address in subrule 117.2(2). The request shall be deemed timely submitted if it is delivered or postmarked within 30 days of the department's mailing of the letter denying the application.

117.10(2) The owner of an outdoor advertising permit which has been revoked or canceled by the department may contest the decision in accordance with 761—Chapter 13. The request for a contested case hearing shall be submitted in writing to the director of the traffic and safety bureau at the address in subrule 117.2(2). The request shall be deemed timely submitted if it is delivered or postmarked within 30 days of the owner's receipt of the revocation notice issued by the department.

117.10(3) Failure to timely request a hearing on the denial, revocation, or cancellation of a permit is a waiver of the right to a hearing and a failure to exhaust administrative remedies.

[ARC 2645C, IAB 8/3/16, effective 9/7/16; ARC 4984C, IAB 3/11/20, effective 4/15/20]

761—117.11 to 117.14 Reserved.

761—117.15(306C) Development directory signing.

117.15(1) Definition. "Development directory sign" means a type of on-premises sign displaying a message that is limited to the names of two or more businesses located within a commercial or industrial development. The sign may also display the name of the development. The sign must be located within the limits of the development but may be located anywhere within the development regardless of land ownership.

117.15(2) Limitation. Each business within the development is limited to its name appearing on not more than two development directory signs visible to traffic proceeding in any one direction on any primary highway.

117.15(3) Commercial or industrial development. A development directory sign must be located within a commercial or industrial development. For the purposes of this rule, a commercial or industrial development is a single premises that meets all of the following requirements:

- a. All of the lots, regardless of whether they are individually owned, are contiguous, except for roadways or driveways providing access to lots or common areas within the development.
- b. No part of the development is separated from another part by a primary highway.
- c. The development is approved for the establishment of commercial or industrial activities by an authorized governing authority, and is occupied by commercial or industrial activities. The term "commercial or industrial activities" is defined in Iowa Code section 306C.10.

d. The development is subject to a common development and common use plan that provides for common areas such as sidewalks, roadways, parking, storage, and service areas, to which all businesses within the development have irrevocable shared use and shared property rights, and for which they have irrevocable shared obligations.

e. The development operates through an association or other entity, actively managed and maintained, through which all lot owners have irrevocable rights and obligations with respect to the development and its common areas.

f. The development and the businesses within the development present themselves to the public as a common development through signage or other marketing efforts.

g. The common areas of the development have necessary and true value to the regular operations of the businesses within the development, and were created for purposes other than establishing eligibility for development directory signing.

[ARC 2645C, IAB 8/3/16, effective 9/7/16]

These rules are intended to implement Iowa Code chapters 306B and 306C and section 306D.4, 23 U.S.C. 131, and 23 CFR 750.705(h).

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[Editorial change: IAC Supplement 1/25/12²]

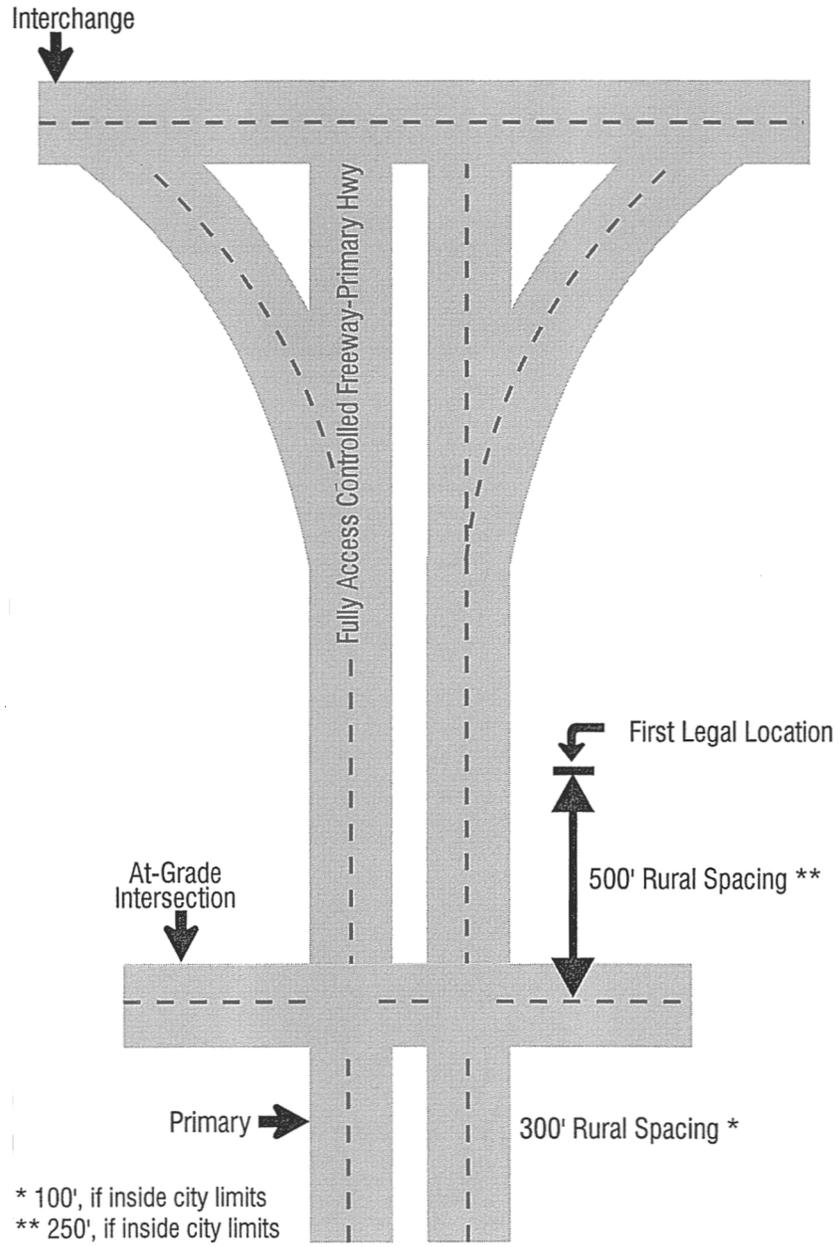
[Filed ARC 2645C (Notice ARC 2543C, IAB 5/25/16), IAB 8/3/16, effective 9/7/16]

[Filed ARC 4984C (Notice ARC 4868C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

¹ Two or more ARCs

² Spacing—Transition to Freeway-Primary Highway diagram replaced with a clearer image.

Spacing--Transition To Freeway-Primary Highway



VEHICLES

CHAPTER 400

VEHICLE REGISTRATION AND CERTIFICATE OF TITLE

[Prior to 6/3/87, Transportation Department[820]—(07.D)Ch 11]

761—400.1(321) Definitions. The definitions in Iowa Code section 321.1 are hereby made part of this chapter. In addition, the following words and phrases, when used in Iowa Code chapter 321 or this chapter, shall have the meanings respectively ascribed to them, except when the context otherwise requires.

“Certificate of title” means a document issued by the appropriate official which contains a statement of the owner’s title, the name and address of the owner, a description of the vehicle, a statement of all security interests and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms “title certificate,” “title only,” and “title” shall be synonymous with the term “Certificate of title.”

“Dealer’s or manufacturer’s stock or inventory” means a vehicle owned by a dealer which is being held for sale or trade and for which the dealer has a duly assigned ownership document as required by Iowa Code section 321.45.

“Electronic” means as defined in Iowa Code section 554D.103.

“Electronic record” means as defined in Iowa Code section 554D.103.

“Electronic signature” means as defined in Iowa Code section 554D.103.

“End user” means a person or entity that directly uses the services of an electronic registration and titling (ERT) service provider to submit an electronic application for certificate of title or registration of a vehicle.

“ERT service provider” means a person or entity authorized by the department under subrule 400.3(16) to submit electronic applications for certificate of title or registration of a vehicle on behalf of an end user to a county treasurer.

“Farm trailer” means a trailer used exclusively by a farmer in the conduct of the farmer’s agricultural operation. The term shall not include a “semitrailer.”

“Final-stage manufacturer” means as defined in Iowa Code section 322.2.

“Half-year fee” means the first semiannual installment of an annual registration fee. The term “half-year registration” shall be synonymous with the term “half-year fee.”

“Hearse” means a motor vehicle used exclusively to transport a deceased person.

“Lien” means an interest in a vehicle which secures payment or performance of an obligation. The term “security interest” shall be synonymous with the term “lien.”

“Manufacturer’s certificate of origin” means a certification signed by the manufacturer, distributor or importer that the vehicle described has been transferred to the person or dealer named and that the transfer is the first transfer of the vehicle in ordinary trade and commerce.

1. The terms “manufacturer’s statement,” “importer’s statement or certificate,” “MSO” and “MCO” shall be synonymous with the term “manufacturer’s certificate of origin.”

2. In addition to the requirements of Iowa Code subsection 321.45(1), the certificate shall contain a description of the vehicle which includes the make, model, style and vehicle identification number. The description of a motorized bicycle shall also specify the maximum speed.

3. For 1992 and subsequent model year vehicles, the form used for manufacturers’ certificates of origin shall be the universal form adopted in 1990 by the American Association of Motor Vehicle Administrators (AAMVA). This requirement does not apply to trailer-type vehicles. A copy of this universal form may be obtained from the vehicle and motor carrier services bureau at the address in subrule 400.6(1).

“Model year,” except where otherwise specified, means the year of original manufacture or the year certified by the manufacturer. For purposes of titling and registration, the model year shall advance one year each January 1.

“*Registered*” means that the appropriate registration fee has been paid for a vehicle and a registration card evidencing payment has been issued to the owner.

“*Registration card*” means a document issued to the owner of a vehicle by the appropriate agency whose duty it is to register vehicles, which contains the name and address of the owner and a description of the vehicle, and which is issued to the owner when the vehicle has been registered. The terms “registration certificate,” “registration receipt” and “registration renewal receipt” are synonymous with the term “registration card.”

“*Security interest*” means an interest in a vehicle which secures payment or performance of an obligation. The term “lien” shall be synonymous with the term “security interest.”

“*Social security number*” means a social security number issued by the United States government.

This rule is intended to implement Iowa Code sections 321.1, 321.8, 321.20, 321.23, 321.24, 321.40, 321.45, 321.50, 321.117, 321.123, 321.134, 321.157 and 322.2.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.2(321) Vehicle registration and certificate of title—general provisions.

400.2(1) *Vehicles subject to registration.* A vehicle subject to registration under the laws of Iowa shall be required to be registered at the time the vehicle is first operated or moved upon a highway in this state.

400.2(2) *Vehicles exempt from titling or registration.* A certificate of title shall not be issued for a vehicle which is exempt from the titling or registration provisions of Iowa Code chapter 321, unless issuance of a certificate of title is specifically authorized in chapter 321.

400.2(3) *Issuance of a certificate of title upon payment of registration fees.* Except as otherwise provided in Iowa Code chapter 321 or this chapter of rules, the current year registration fee and any delinquent registration fees and penalties, if any, shall be paid prior to issuance of a certificate of title.

400.2(4) *Trailers with an empty weight of 2000 pounds or less.* Certificates of title shall not be issued for trailers with an empty weight of 2000 pounds or less. However, these trailers shall be subject to the registration fees provided in Iowa Code section 321.123.

400.2(5) *Vehicles owned by the government.* A certificate of title shall be issued for a vehicle owned by the government when the vehicle is first registered. However, vehicles owned by the government shall be exempted from registration and titling fees. Also, a certificate of title shall not be issued for a government-owned vehicle if a certificate of title would not be issued if the vehicle were owned by someone other than the government.

400.2(6) *Vehicles leased by the government.* Vehicles leased by the government for a period of 60 days or more are exempted from payment of registration fees. A copy of the lease agreement, certificate of lease, or other evidence that the vehicle is being leased by the government shall be required in order to obtain this exemption. However, the lessor is not exempted from the requirements for obtaining a certificate of title as set out in Iowa Code chapter 321 and these rules, including payment of the appropriate certificate of title fee.

400.2(7) *Special mobile equipment.* Rescinded IAB 3/7/90, effective 4/11/90.

400.2(8) *Private school buses, fire trucks, authorized emergency vehicles, and transit buses.* In accordance with Iowa Code sections 321.18, 321.19 and 321.22, private school buses, fire trucks not owned or operated for a pecuniary profit, certain authorized emergency vehicles owned and operated by nonprofit organizations, and urban and regional transit system buses are exempt from the payment of registration fees. However, these vehicles are not exempt from the requirements for obtaining a certificate of title as set out in Iowa Code chapter 321, including payment of the appropriate certificate of title fee.

400.2(9) *Towable recreational vehicles.* For purposes of registration and titling under Iowa Code chapter 321 and this chapter, a towable recreational vehicle as defined in Iowa Code section 322C.2

shall be considered a travel trailer or fifth-wheel travel trailer, as those terms are defined in Iowa Code section 321.1, as applicable.

This rule is intended to implement Iowa Code sections 321.18 to 321.22, 321.24, 321.123 and 322C.2(19).

[ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.3(321) Application for certificate of title or registration for a vehicle.

400.3(1) *Application form.* To apply for a certificate of title or registration for a vehicle, the owner of the vehicle shall complete an application form prescribed by the department, which may be electronic. Application shall be made in accordance with Iowa Code chapter 321, these rules, and other applicable provisions of law.

400.3(2) *Full legal name.* Full legal names shall be given on the application. Civilian or military titles and nicknames shall not be used.

400.3(3) *Information about owner, lessee and primary user.*

a. Iowa Code sections 321.20 and 321.109 list the information that must be disclosed by the owner, lessee and primary user on the application.

b. A firm, association, corporation, or trust that is not required to have a federal employer identification number shall disclose the social security number, Iowa driver's license number or Iowa nonoperator's identification card number of an authorized representative of the firm, association, corporation, or trust. The authorized representative of a trust is the trustee unless otherwise specified in the trust agreement or the certification of trust as defined in Iowa Code section 633A.4604.

400.3(4) *Plate number and validation number.* If the owner has registration plates that have been assigned to the owner and affixed to the vehicle, the owner shall list the plate number on the application form. The validation number from the validation sticker shall also be listed.

400.3(5) *Birth or registration month.* If the vehicle is owned by one individual, the individual's month of birth shall be listed on the application form and shall determine the registration year. If the vehicle is owned by two or three individuals, the month of birth of one of the individuals shall be listed and shall determine the registration year. If the vehicle is owned by a partnership, corporation, association, or governmental subdivision, the birth or registration month shall be left blank on the application; the county treasurer shall determine the month of registration.

400.3(6) *Model year.* The application shall include the model year of the vehicle.

400.3(7) *Purchase information.* The application shall include the date of purchase or acquisition and, if the vehicle was not purchased from a dealer, the purchase price.

400.3(8) *Vehicle color.* The application shall include the vehicle color.

400.3(9) *Foreign registered vehicle.* If the vehicle is registered in a foreign jurisdiction, the application shall include the date the vehicle was brought into Iowa.

400.3(10) *Signature of applicant.* The owner shall sign the application form in ink, unless submitted electronically.

400.3(11) *Dealer certification.*

a. If the vehicle is a new vehicle which has been sold to the owner by a dealer, as defined in Iowa Code section 321.1, the dealer shall certify the following on the application form: sale price of the vehicle, the amounts allowed for property traded in, nontaxable charges and rebates, the tax price of the vehicle, the date that a "Registration Applied For" card was issued, and the registration fee collected.

b. The certification shall include the dealer's number and name and shall be signed by the dealer or an authorized representative of the dealer. The signature may be electronic when the application form is submitted electronically in a manner approved by the department.

400.3(12) *Weigh ticket.* If application is being made to lower the tonnage on any motor truck, bus or truck tractor, the county treasurer may require a copy of a stamped weigh ticket issued by any public scale.

400.3(13) *Credits.* See rule 761—400.60(321) for:

Credit for unexpired registration fee.

Credit for transfer to spouse, parent or child.

Credit from/to apportioned registration.

Assignment of credit and registration plates from lessor to lessee.

400.3(14) *Leased vehicle.* As required by Iowa Code section 423.26, the lessor shall list the lease price of the vehicle on the application form.

400.3(15) *Affidavit of correction.* As provided in Iowa Code section 321.23A, the county treasurer or the department may accept an affidavit of correction on a form prescribed by the department.

a. The affidavit may be used only to correct those errors, erasures or alterations listed on the affidavit.

b. The affidavit must contain the signatures of all parties to the original error, erasure or alteration.

c. Only an original, notarized affidavit shall be accepted.

d. The affidavit must be surrendered with the document that contains the error, erasure or alteration to be corrected.

e. The affidavit may be accepted to correct errors, erasures or alterations on either an Iowa title or a foreign title.

400.3(16) *Electronic applications.*

a. Applications for certificate of title or registration of a vehicle may be submitted electronically via web-based services offered and maintained by ERT service providers authorized by the department. To be authorized to serve as an ERT service provider, the ERT service provider must establish to the satisfaction of the department that the ERT service provider has the technical, financial, legal, and administrative capacity to meet the department's requirements for submission of electronic applications and must execute an agreement, in a form and content determined by the department, that authorizes and permits the ERT service provider to interact with the department's vehicle title and registration system via an application program interface established by the department and to submit electronic applications on behalf of end users that choose to use the ERT service provider's services to submit an application electronically. Agreements executed by ERT service providers under this paragraph shall include provisions that address security, financial responsibility, privacy, termination, and any other matters deemed appropriate by the department.

b. An agreement executed by an ERT service provider is a condition of authorization and permission only. An ERT service provider authorized by the department is not a contractor, vendor, employee, or agent for the department, the state of Iowa, or any county treasurer accepting electronic applications, and shall not be entitled to compensation from the department, the state of Iowa, or any county treasurer for any service, transaction, or other act rendered as an ERT service provider. The ERT service provider remains solely liable and responsible for the ERT service provider's services and activities as an ERT service provider and shall defend, indemnify and hold harmless the department, any county treasurer, the state of Iowa, and its, or their agents, officers, heirs, assigns, and employees of and from any and all damages, claims, penalties, debts owed, or any other form of liability arising from or related to the ERT service provider's service, performance, errors, acts, or omissions. An ERT service provider that chooses to provide service under the department's permission and authorization does so at the ERT service provider's sole risk and has no claim or right against the department, any county treasurer, or the state of Iowa for fees, costs, profits, loss of profits, interruption of business, or any other form of compensation, remuneration, liability, or damages arising from or related to the ERT service provider's activity as an ERT service provider or inability to serve as an ERT service provider.

c. An ERT service provider authorized by the department may establish web-based services to allow end users to submit applications via an electronic interface established and maintained by the ERT service provider and to submit the applications on behalf of the end user to county treasurers via the department's vehicle title and registration system and application program interface established by the department. In doing so, the ERT service provider is acting as a contractor or vendor for the end user and not the department, any county treasurer, or the state of Iowa, and remains solely responsible to the end user for any failure to perform or breach of performance or agreement. When the end user is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C, "end user" includes the motor vehicle dealer and any person with an interest in the vehicle that is the subject of the application. The ERT service provider may charge the end user a fee for services rendered as an ERT service provider.

d. In addition to the documentary fee authorized under Iowa Code section 322.19A, an end user that is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C may pass and charge to a customer the fees or costs incurred by the motor vehicle dealer to submit the customer's application through an ERT service provider's services as a third-party cost or fee under Iowa Code section 322.19A(1), provided that the motor vehicle dealer discloses the charge to the customer before submitting the application. The documentary fee charged by the motor vehicle dealer shall not exceed the amount authorized by Iowa Code section 322.19A(3). Neither the ERT service provider nor the motor vehicle dealer shall charge a customer for creation or delivery of a "registration applied for" card.

e. An ERT service provider authorized by the department has no authority to approve or deny applications. Acceptance of an application by an ERT service provider is not approval of the application. An application is not considered to be formally submitted until it is electronically transmitted by the ERT service provider to the county treasurer via the department's vehicle title and registration system and the application program interface established by the department. The county treasurer remains responsible for approving or denying the application and may reject the application for any reason permitted or required by state or federal law or regulation.

f. An authorized ERT service provider is responsible for the ERT service provider's payment solution and for all payment transaction security and compliance with all applicable standards associated with the payment solution or solutions offered by the ERT service provider. The ERT service provider shall transfer title and registration fees collected by the ERT service provider directly to an account designated by the county treasurer responsible for the transaction via automated clearing house (ACH) transfer and the fees shall be available to the county treasurer no later than three business days following the submission of a transaction for which the fees were paid. Funds received by the ERT service provider shall be held until transfer to the county treasurer's account in a bank insured by the Federal Deposit Insurance Corporation. The ERT service provider shall be responsible for reconciling insufficient funds from an end user.

g. Fees submitted electronically are not deemed to be received until deposited into the county treasurer's account via completion of the ACH transfer. The end user remains responsible for fees submitted via an ERT service provider and the end user's responsibility for payment of any required fees is not waived or excused by the ERT service provider's failure to complete the transfer. As a condition of authorization and permission to serve as an ERT service provider and before the ERT service provider may offer services, the ERT service provider shall furnish a surety bond executed by the ERT service provider as principal and executed by a corporate surety company, licensed and qualified to do business within the state of Iowa. The bond shall run to the state of Iowa, be in the amount of \$150,000 and be conditioned upon the faithful compliance by the ERT service provider of all obligations imposed upon the ERT service provider by any applicable state or federal law or regulation, including the terms of this chapter, the authorizing agreement executed by the ERT service provider under this chapter, and any terms or conditions existing between the ERT service provider and any end user using the ERT service provider's services. The ERT service provider shall indemnify any end user that uses the ERT service provider's services of and from any loss or damage occasioned by the failure of the ERT service provider to so comply, including but not limited to the complete and timely submission to the county treasurer of the title and registration fees required for a given transaction. The bond shall be filed with the department before the ERT service provider may begin or offer services as an ERT service provider. The aggregate liability of the surety shall not exceed the amount of the bond.

h. The ERT service provider shall provide accounting reports of all fees received and transferred to each respective county treasurer, in a manner determined by the department.

i. The ERT service provider shall submit to audits by the department and the state auditor, which shall be at least yearly but may be more frequently if determined necessary by the department or the state auditor.

j. An application submitted electronically must meet all legal requirements for the transaction in question, and no requirement shall be excused or waived as a result of submitting the transaction electronically. However, wherever a signature is required, the signature may be an electronic signature, as determined by the department and according to methods approved by the department. Wherever

an electronic solution approved by the department requires the submission of scanned documents, the scanned documents shall be of a quality and resolution determined by the department, which shall at a minimum meet any applicable state or federal standard or requirement, and shall completely capture and represent the original document. The department and any county treasurer processing an application retain the right under Iowa Code section 321.13 to determine the genuineness, regularity, and legality of the application and any scanned document submitted as part of the application and may withhold approval of the application and require presentation of the original document whenever the scanned document is of insufficient quality, content, or appearance to determine the same. An end user that submits a scan of an original document as part of an electronic application shall retain the original document for a period of six months. An end user shall make all such original documents available for inspection by the department at the department's request. An end user that is a business entity shall retain the documents at the end user's principal place of business in Iowa. Anything in this paragraph notwithstanding, lessors required to retain a damage disclosure statement under Iowa Code section 321.69(4), and authorized vehicle recyclers licensed under Iowa Code chapter 321H and motor vehicle dealers licensed under Iowa Code chapter 322 required to retain damage disclosure statements under Iowa Code section 321.69(6) shall retain the original document for a period of five years from the date of the statement, as required therein.

k. An end user that is a motor vehicle dealer licensed by the department under Iowa Code chapter 322 or 322C and that electronically submits an application on behalf of the person to whom the dealer is transferring the vehicle shall disclose to the person that the application will be submitted electronically and shall obtain the person's written authorization to submit the application on the person's behalf. The written authorization shall be retained at the motor vehicle dealer's principal place of business for a period of six months from the date of application and shall be available for inspection by the department at the department's request. The motor vehicle dealer shall also review with and disclose to the person all details of the application, before submitting the application, and shall provide a complete, true, and accurate copy of the application to the person immediately after submitting the application. The written authorization shall be submitted electronically as a scanned document with the electronic application.

l. An authorized ERT service provider shall retain all data, information, records, and electronic records associated with an electronic application or transaction submitted or transacted through the ERT service provider for a period of at least six months, or longer as required by applicable state or federal law or regulation, and shall make all such data, information, and records available to the department at the department's request. This includes but is not limited to the identity of the end user that initiated the electronic application or transaction. Identity information for end users shall be maintained at the entity and individual level, meaning that the ERT service provider must implement and maintain secure profile management that is capable of authenticating and verifying the identity of any entity that initiated the application or transaction and the individual officer, employee, or agent within the entity that was authorized by the entity to initiate the application or transaction.

m. The ERT service provider shall hold and protect all personal information as required by Iowa Code section 321.11 and the federal Driver's Privacy Protection Act, 18 U.S.C. § 2721 et seq. (the DPPA), shall only use or release such personal information for purposes necessary to perform services as an ERT service provider, and shall release such personal information for no other purposes or use except as required to comply with legal or administrative matters as permitted under the DPPA. The ERT service provider shall immediately advise the department of any suspected or actual unauthorized release of personal information or highly restricted personal information and shall notify the entity and individual whose personal information or highly restricted personal information was released in an unauthorized manner.

This rule is intended to implement Iowa Code sections 321.1, 321.8, 321.20, 321.23 to 321.26, 321.31, 321.34, 321.46, 321.105A, 321.109, 321.122, 322.19A and 423.26.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.4(321) Supporting documents required. This rule describes the basic supporting documents to be submitted by an applicant for a certificate of title or registration.

400.4(1) *New vehicle.* If application is made for a new vehicle, a manufacturer's certificate of origin, properly assigned to the applicant, shall be submitted. A manufacturer's certificate of origin shall not be accepted if the assignment to the applicant is made by any person other than the manufacturer, importer or distributor, a licensed motor vehicle dealer franchised to sell that line-make of vehicle, or a final-stage manufacturer motor vehicle dealer licensed under rule 761—425.11(322).

a. The first person, including a dealer not franchised to sell that line-make of vehicle, who is assigned the manufacturer's certificate of origin shall obtain a certificate of title and register the vehicle.

b. An uncanceled security interest noted on the reverse side of a manufacturer's certificate of origin (MCO) shall be noted as a separate security interest on the certificate of title, in addition to any security interest acknowledged by the applicant, unless the applicant indicates in the security interest area on the title application that the security interest is the same as the one noted on the reverse side of the MCO.

c. If a 1980 or subsequent model year vehicle is manufactured by a person other than the original manufacturer, both the original manufacturer's certificate of origin and the final-stage manufacturer's certificate of origin shall be submitted if the vehicle's original line-make is changed by the final-stage manufacturer. All assignments or reassignments of ownership of the vehicle shall be made on the final-stage manufacturer's certificate of origin. The face of the original manufacturer's certificate of origin shall be stamped in bold type with the statement: "Final-stage manufacturer's MCO has been issued on this vehicle." The original manufacturer's vehicle identification number shall be listed on the final-stage manufacturer's certificate of origin.

d. If a final-stage manufacturer is a motor vehicle dealer licensed under rule 761—425.11(322), the final-stage manufacturer may reassign the original manufacturer's certificate of origin to the retail buyer.

400.4(2) *Used vehicle registered or titled in this state.* The last issued certificate of title, properly assigned to the applicant, shall be submitted, unless the applicant is an insurer applying for a salvage certificate of title under Iowa Code section 321.52(4). An uncanceled security interest noted on the face of the certificate of title shall be noted on the face of the certificate of title issued to the applicant, in addition to any security interest acknowledged by the applicant. If the vehicle is not subject to titling provisions, the last issued registration receipt or bill of sale, properly assigned to the applicant, shall be submitted.

400.4(3) *Used vehicle from a foreign jurisdiction.* If the vehicle was subject to the issuance of a certificate of title in the foreign jurisdiction, the certificate of title issued by the foreign jurisdiction to the applicant or properly assigned to the applicant shall be submitted, unless the applicant is an insurer applying for a salvage certificate of title under Iowa Code section 321.52(4).

a. A security interest, noted on the face of the foreign certificate of title, which has not been canceled, shall be noted on the face of the certificate of title issued to the applicant, in addition to any security interest acknowledged by the applicant.

b. A certificate of title issued in a foreign jurisdiction may be assigned to a motor vehicle dealer in another jurisdiction, and the dealer may reassign the certificate of title to the applicant. An assignment or reassignment form issued by a foreign jurisdiction may be used with a foreign title to complete an assignment or reassignment of ownership from a foreign motor vehicle dealer to the applicant, provided the ownership chain is complete.

c. An Iowa licensed motor vehicle dealer who acquires a vehicle registered in another state or country may reassign the foreign certificate of title to the applicant, as provided in Iowa Code subsection 321.48(2) and rule 761—400.27(321,322).

d. A person who registers a foreign vehicle under Iowa Code subsection 321.23(3) shall be issued a nontransferable-nonnegotiable registration. To transfer ownership of the vehicle, the owner must first obtain an Iowa certificate of title except as follows: If ownership is transferred to an Iowa licensed motor vehicle dealer as provided in Iowa Code subsection 321.23(3), the foreign certificate of title may be assigned to the dealer; the owner is not required to obtain an Iowa title. The dealer may then reassign the foreign title, as provided in Iowa Code subsection 321.48(2) and rule 761—400.27(321,322).

e. If the vehicle was not subject to the issuance of a certificate of title in the foreign jurisdiction, the registration document issued by the foreign jurisdiction to the applicant or properly assigned to the applicant shall be submitted.

(1) If the foreign registration document is not issued in the applicant's name and does not contain an assignment of ownership form, a bill of sale conveying ownership from the owner as listed on the foreign registration document to the applicant shall be submitted with the foreign registration document.

(2) Upon receipt of the foreign registration document, the county treasurer shall issue a nontransferable—nonnegotiable registration unless the foreign registration document has been approved by the department.

(3) Acceptance of the foreign registration document shall be determined by the department on an individual basis, if the county treasurer of the county where the certificate of title is to be issued cannot determine whether the document is acceptable.

f. If a trailer weighing 2000 lbs. or less is exempt from the issuance of a certificate of title and registration in the foreign jurisdiction, a bill of sale conveying ownership to the applicant, if acquired by a resident from a nonresident, or an affidavit of ownership signed by the applicant, if the applicant is establishing residence in this state, shall be submitted.

g. If a motor vehicle is exempt from the issuance of a certificate of title and registration in the foreign jurisdiction, the bonding procedures as provided in Iowa Code section 321.24 shall be followed.

400.4(4) *Used vehicle acquired by a resident of this state from a government agency.* If the vehicle was acquired from an agency of the federal government, the applicant shall surrender the government bill of sale, General Services Administration Form 97, or Internal Revenue Service Form 2435, properly assigned to the applicant. If the vehicle was acquired from the state of Iowa or a subdivision of government, the applicant shall surrender the Iowa certificate of title issued in the name of the agency, properly assigned to the applicant.

400.4(5) *Manufactured or mobile home.* If the vehicle described on the application is a manufactured or mobile home with an Iowa title, the applicant shall submit a tax clearance form to show that no taxes are owing, unless the title has been issued to a manufactured or mobile home retailer licensed under Iowa Code chapter 103A. The form may be obtained by any owner of record of the manufactured or mobile home from the county treasurer.

400.4(6) *Vehicle acquired by a resident of this state by operation of law.* If the vehicle was acquired by the applicant by operation of law as specified in Iowa Code section 321.47, the last issued certificate of title shall be submitted by the applicant, or when that is not possible, presentation of satisfactory proof of the applicant's ownership and right of possession to the vehicle shall be submitted by the applicant. Proof of ownership may consist of a foreclosure sale affidavit, artisan's or storage lien affidavit, affidavit of death intestate, abandoned vehicle sales receipt, peace officers bill of sale or court order. See also subrules 400.14(4) and 400.14(5).

400.4(7) *Foreign ownership document issued in a language other than English.* A foreign ownership document issued in a language other than English may be required to be reproduced in writing in English and certified to be a correct translation by a person qualified to translate that particular language. The English translation and certification shall be submitted with the foreign ownership document.

400.4(8) *Titles from foreign jurisdictions.*

a. Except as provided in paragraph "*b*" of this subrule, a certificate of title issued by a foreign jurisdiction shall not be accepted if the title contains an alteration or erasure.

b. An affidavit of correction form issued by a foreign jurisdiction that corrects the certificate of title issued by the foreign jurisdiction shall be accepted only for the reason listed on the affidavit of correction form. However, acceptance of an affidavit of correction form that corrects an odometer statement or a designation shall be determined by the department on an individual basis.

400.4(9) *Applications in the name of trusts.* An application in the name of a trust shall be accompanied by a copy of all documents creating or otherwise affecting the trust or by the certification of trust as defined in Iowa Code section 633A.4604. The certification of trust may be signed by any trustee or the attorney for any trustee. The application shall be signed by the number of trustees as specified in the trust agreement or the certification of trust and the applicant shall provide the

department with the document specifying the required signatories for the trust. If neither the trust nor the certification of trust specifies the required signatories, the application may be signed by any trustee or attorney for the trustee. Each signature on the application shall be followed by the words “as trustee” or “as attorney for the trustee.”

400.4(10) Supporting document retained by county treasurer. All supporting documents, except those submitted pursuant to subrule 400.3(16), shall be retained by the county treasurer.

This rule is intended to implement Iowa Code sections 321.20, 321.23, 321.24, 321.30, 321.31, 321.45 to 321.50, 321.67 and 322.3.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3449C, IAB 11/8/17, effective 12/13/17; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.5(321) Where to apply for registration or certificate of title.

400.5(1) Except as otherwise provided, application for the registration of a vehicle or a certificate of title for a vehicle, or transfers thereof, shall be made to the county treasurer as described in Iowa Code chapter 321. When none of the primary users of a non-resident-owned vehicle are located in Iowa, the vehicle may be registered by the county treasurer of any county.

400.5(2) Application shall be made to the department’s vehicle and motor carrier services bureau for the following:

a. Titling and registration of vehicles owned by the government. This requirement does not apply to manufactured or mobile homes subject to a public bidder sale as explained in Iowa Code subsection 321.46(2).

b. Registration of vehicles leased by the government for a period of 60 days or more.

c. Registration of urban and regional transit system buses.

d. Registration of fire trucks not owned and operated for a pecuniary profit.

e. Registration of certain authorized emergency vehicles owned and operated by nonprofit organizations.

f. Registration of private school buses.

g. Registration of vehicles under the provisions of Iowa Code subsection 321.23(4), relating to restricted-use vehicles.

400.5(3) Application for a certificate of title for a vehicle subject to apportioned registration under Iowa Code chapter 326 may be made to either the county treasurer or to the department’s vehicle and motor carrier services bureau.

400.5(4) Application for apportioned registration shall be made to the department’s vehicle and motor carrier services bureau. See 761—Chapter 500.

This rule is intended to implement Iowa Code sections 321.18 to 321.23, 321.46(2), and 321.170.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.6(17A) Addresses, information and forms. Assistance under this chapter is available as follows:

400.6(1) Information and forms for vehicle registration, certificate of title, or other procedures covered under Iowa Code sections 321.18 to 321.173 may be obtained from the county treasurer or by mail from the Vehicle and Motor Carrier Services Bureau, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278; in person at Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3264; or on the department’s website at www.iowadot.gov.

400.6(2) Information for investigations under this chapter may be obtained from the Bureau of Investigation and Identity Protection, Iowa Department of Transportation, 6310 SE Convenience Blvd., Ankeny, Iowa 50021; by telephone at (515)237-3050; or on the department’s website at www.iowadot.gov.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.7(321) Information appearing on title or registration. In addition to the requirements of Iowa Code sections 321.24, 321.52, 321.69, 321.71 and 322G.12, a certificate of title or registration receipt or both shall contain the following information when applicable:

400.7(1) Registration expiration date.

400.7(2) Registration month, as explained in rule 761—400.3(321).

400.7(3) Name and address of last titled owner.

400.7(4) Description of the vehicle, including the following items. These items may be represented on the title and registration by code letters or numbers.

a. Vehicle identification number.

b. Type, such as automobile, trailer, truck, etc.

c. Style.

d. Make, model, and model year.

e. Number of engine cylinders.

f. Color.

g. Weight and registered gross weight.

h. The square footage of floor space of a manufactured or mobile home or travel trailer, as determined by measuring the exterior.

i. The odometer mileage and whether the mileage is “actual,” “not actual,” or “exceeds mechanical limits.”

400.7(5) Previous Iowa title number or the name of the foreign jurisdiction if the previous title is a foreign title.

400.7(6) Plate number and previous registration number.

400.7(7) List price or value.

400.7(8) Penalties and title, registration and security interest receipt numbers.

400.7(9) The following phrase stamped on the reassignment portion of a manufactured or mobile home title: “Dealer reassignment not authorized on this certificate of title.”

400.7(10) The designation required by 761—Chapter 405. A vehicle may have no more than one designation. The referenced rules explain which designation takes precedence when more than one designation could apply.

400.7(11) Full legal name of owner.

a. When the name of an owner changes from that which is printed on the title or registration issued to the owner, the owner shall submit to the county treasurer one of the following documents:

(1) Court order for a name change. The court order must contain the full name, date of birth, and court seal.

(2) Divorce decree.

(3) Marriage certificate.

b. This subrule does not apply to owners that are firms, associations, corporations, or trusts.

c. When the name of an owner changes from that which is printed on the registration card, the owner shall apply for a replacement registration card.

This rule is intended to implement Iowa Code sections 321.24, 321.31, 321.40, 321.45, 321.52, 321.69, 321.71, 321.124 and 322G.12.

[ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.8(321) Release form for cancellation of security interest.

400.8(1) A secured party may use a form prescribed by the department to note the cancellation of a security interest.

400.8(2) The secured party may also note the cancellation in a statement written on the secured party’s letterhead if the statement is notarized and contains the following information: county that issued the title; title number; security interest number; vehicle identification number; vehicle owner’s name; secured party’s name, street address, city, state and ZIP code; date the security interest was canceled; and signature of an authorized representative of the secured party.

400.8(3) The secured party shall forward the original cancellation form or statement to the department or to the county treasurer of the county where the title was issued. Facsimiles and photocopies are not acceptable.

400.8(4) The secured party shall note the cancellation on the face of the title, attach a copy of the release form to the title as evidence of cancellation, and forward the title to the next secured party or, if there is no other secured party, to the person designated by the owner or, if there is no person designated, to the owner.

This rule is intended to implement Iowa Code section 321.50.
[ARC 4343C, IAB 3/13/19, effective 4/17/19]

761—400.9(321) Security interest notation, 30-day limit. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.10(321) Assignment of security interest. A security interest noted on a certificate of title may be assigned to another secured party without losing the seniority of the security interest by complying with the procedure in Iowa Code section 321.50 or with the following procedure:

400.10(1) Notice of assignment. The secured party listed on the title certificate shall make the following notation in the cancellation portion of the certificate of title where security interest is noted “Assigned to (name of assignee).” The date, name of secured party and signature of the person noting the assignment shall be completed in the cancellation portion pertaining to the security interest.

400.10(2) Application for notation of security interest. The assignee shall complete an application for notation of a security interest on the form provided by the department. The application form shall be signed by the assignee in the space where the signature of the owner is ordinarily required. The signature of the owner shall not be required on an assignment of a security interest.

400.10(3) Submission of documents to county treasurer. The certificate of title, application for notation of security interest and appropriate notation fee shall be submitted to the county treasurer of the county where the certificate of title was issued or will be issued.

a. If there are additional security interests noted on the certificate of title, the seniority of the assignee’s security interest may be preserved by issuance of a certificate of title in lieu of the original, on which the assignee’s security interest shall be noted in the same seniority as the assignor’s.

b. A receipt for notation of security interest form shall be processed and the new receipt number shall be listed in the appropriate space provided. The original notation date shall also be listed and the words “by assignment” shall be listed following the name of the assignee.

This rule is intended to implement Iowa Code section 321.50.

761—400.11(321) Sheriff’s levy, restitution lien, and forfeiture lien noted as security interests.

400.11(1) A sheriff’s levy may be noted as a security interest on a certificate of title if the sheriff so desires. To apply for a notation of a security interest, the sheriff or the sheriff’s deputy shall complete an application form prescribed by the department. The sheriff or sheriff’s deputy shall sign the application in the space where the signature of the owner is ordinarily required. The signature of the owner is not required. The appropriate notation fee shall be submitted with the application form to the county treasurer of the county where the certificate of title was issued. If the certificate of title is not surrendered with the application, the county treasurer shall notify the holder of the certificate of title in the manner prescribed in Iowa Code section 321.50.

400.11(2) A restitution or forfeiture lien may be noted as a security interest on a certificate of title if the county attorney so desires. To apply for a notation of a security interest, the county attorney or designee shall complete an application form prescribed by the department. The county attorney or designee shall sign the application in the space where the signature of the owner is ordinarily required. The signature of the owner is not required. A lien notation fee is not required. If the certificate of title is not surrendered with the application, the county treasurer shall notify the holder of the certificate of title in the manner prescribed in Iowa Code section 321.50.

This rule is intended to implement Iowa Code section 321.50 and chapter 809A.
[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.12(321) Replacement certificate of title.

400.12(1) When a certificate of title is lost, destroyed or altered, the owner or lienholder shall apply for a replacement certificate of title. If a security interest noted on the certificate of title was released by the secured party on a separate form, but the secured party has not delivered the original certificate of title to the appropriate party, the owner may apply for a replacement certificate of title as provided in Iowa Code section 321.42.

400.12(2) Application for a replacement certificate of title shall be made on a form prescribed by the department. All owners of the vehicle as listed on the certificate of title shall sign the application form. If an owner is deceased, the signatures and documents specified in subrules 400.14(4) and 400.14(5) shall be required in lieu of the deceased owner's signature. A person entitled to vehicle ownership under the laws of descent and distribution shall sign the required forms and shall insert the words "heir at law" following the signature.

This rule is intended to implement Iowa Code section 321.42.

761—400.13(321) Bond required before title issued. An applicant for a certificate of title who cannot provide the supporting documents required in rule 761—400.4(321) shall be required to file a bond as a condition to obtaining a title and registration plates.

400.13(1) Procedures. This subrule describes the procedures to be followed to obtain a "bonded" certificate of title. The procedures described are in addition to the regular procedures for titling and registering a vehicle.

a. The applicant shall submit a bond application to the vehicle and motor carrier services bureau on a form prescribed by the department. The application shall be accompanied by evidence of ownership of the vehicle.

b. The department shall search the state files to determine if there is an owner of record for the vehicle and if the vehicle has been reported stolen or embezzled.

(1) If a record is found, the applicant shall complete a request for release of personal information form explaining that the applicant is the current owner and is requesting a duplicate title. The department shall mail the release by first-class mail to the owner of record, at the owner's last-known address.

(2) If the department receives no response from the owner of record within ten days after the date of mailing or the owner of record does not want the owner's personal information released, the department will continue processing the bond application.

c. If the department determines that the applicant has complied with this rule, that there is sufficient evidence to indicate that the applicant is the rightful owner, and that there is no known unsatisfied security interest, the department shall determine the current value of the vehicle and notify the applicant to deposit cash or file a surety bond with the department in an amount equal to one and one-half times the current value of the vehicle.

d. After the cash deposit or surety bond has been deposited, a motor vehicle investigator of the department may examine the vehicle to verify the information submitted on the application is correct. The owner of the vehicle may drive or tow the vehicle to and from the examination location after completing an affidavit to drive on a form provided by the department. The form shall state that the vehicle is reasonably safe for operation, and the form must be signed by the owner. After verifying the information, the investigator shall authorize the county treasurer to issue a title for and register the vehicle. Should the vehicle not meet the equipment requirements of Iowa Code chapter 321, the investigator shall authorize the county treasurer to issue a title and registration but instruct the county treasurer to immediately suspend the registration until such time as the vehicle meets these equipment requirements. If applicable, the investigator shall also affix an assigned vehicle identification number to the vehicle.

e. The applicant shall then make application for a certificate of title and registration.

400.13(2) Disapproval. If the department determines that the applicant has not complied with this rule, that there is sufficient evidence to indicate that the applicant may not be the rightful owner, or that there is an unsatisfied security interest, then the department shall not authorize issuance of a certificate of title or registration receipt and shall notify the applicant in writing of the reason(s).

400.13(3) Junked vehicle. A certificate of title shall not be reinstated for a vehicle that has been issued a junking certificate unless the junking certificate was issued in error, as explained in rule 761—400.23(321), or the vehicle qualifies as an antique vehicle under Iowa Code subsection 321.115(1).

This rule is intended to implement Iowa Code sections 321.24 and 321.52.
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.14(321) Transfer of ownership. The following procedures shall apply for all titling and registration purposes:

400.14(1) Transfer of vehicle owned by two or three persons.

a. If the names of the owners of a vehicle on the certificate of title or on the manufacturer's certificate of origin are joined by the word "or," as in "John Doe, Jane Doe or Mary Doe," then the signature of any of these owners is sufficient to transfer title or to junk the vehicle.

b. If ownership of a vehicle is stated as a name or names followed by the words "Doing Business As" or the initials "DBA" and another name, only the name of an owner followed by the signature of an authorized representative of an owner is required to transfer title or to junk the vehicle.

EXAMPLE: Ownership is stated as "John Smith and Mary Smith DBA Smith Repair." Jane Doe is an authorized representative of John Smith and Mary Smith. To transfer ownership, Jane Doe may sign as "John Smith and Mary Smith DBA Smith Repair, by Jane Doe," "John Smith and Mary Smith by Jane Doe," or Smith Repair by Jane Doe."

c. In all other cases the signature of each named owner is required.

400.14(2) Assignment of title to two or three persons. If a certificate of title or a manufacturer's certificate of origin is assigned to two or three persons with their names joined by the word "or," as in "John Doe, Jane Doe or Mary Doe," then a certificate of title may be issued to any one of these persons, or to any two or all three of these persons with their names joined by the word "or." However, a certificate of title shall only be issued to persons who have signed the application for title.

400.14(3) Organizational ownership.

a. When a vehicle is owned by a partnership, corporation, association, governmental unit, or private organization, the signature of its authorized representative is required.

b. When a vehicle is owned by a trust, the title shall be accompanied by a copy of all documents creating or otherwise affecting the trust or by the certification of trust as defined in Iowa Code section 633A.4604. The certification of trust may be signed by any trustee or the attorney for any trustee. The title shall be signed by the number of trustees as specified in the trust agreement or the certification of trust as defined in Iowa Code section 633A.4604 and the transferor shall provide the department with the document specifying the required signatories for the trust. If neither the trust nor the certification of trust specifies the required signatories, the title may be signed by any trustee or attorney for the trustee. Each signature on the title shall be followed by the words "as trustee" or "as attorney for the trustee."

400.14(4) Death with a will. When ownership is transferred according to a decedent's will, a certified copy of the court order or the letter of appointment appointing the person assigning the title as executor of the will shall be required.

400.14(5) Death without a will. When ownership is transferred from a decedent without a will and there is no administration of the estate, an affidavit of death intestate form signed by the clerk of court shall be required. When ownership is transferred from a decedent without a will but there is an administration of the estate, a copy of the court order or the letter of appointment appointing the person assigning the title as administrator shall be required.

400.14(6) Power of attorney. An attorney in fact may act for the owner(s) if the appointment is shown on a power of attorney form. Power of attorney forms are available from the department but other forms may be accepted if they contain all necessary information. The power of attorney form or a certified true copy shall be kept by the county treasurer and attached to the document to which it applies.

This rule is intended to implement Iowa Code sections 321.20, 321.24, 321.45, 321.47, 321.49, and 321.67.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.15(321) Cancellation of a certificate of title.

400.15(1) The department shall cancel a certificate of title when authorized by any provision of law or when it has reasonable grounds to believe that the title has not been surrendered to the county treasurer as provided in Iowa Code section 321.52 or when the vehicle has been stolen or embezzled from the rightful owner or seized under the provisions of Iowa Code section 321.84, and the person holding the certificate of title, purportedly issued for the vehicle, has no immediate right to possession of the vehicle.

400.15(2) The decision to issue a new certificate of title or to allow the previous title to be reinstated through a replacement title application process or to take any other action regarding ownership of the vehicle for which the current title has been canceled shall be determined after an investigation and recommendation by a motor vehicle investigator of the department.

This rule is intended to implement Iowa Code section 321.101.

761—400.16(321) Application for certificate of title or original registration for a specially constructed, reconstructed, street rod or replica motor vehicle.

400.16(1) *Definitions applicable to this rule.*

a. “*Ownership document for the vehicle*” means the certificate of title, the manufacturer’s certificate of origin, the junking certificate, or other evidence of ownership acceptable to the department.

b. “*Ownership documents for essential parts*” means bills of sale for all essential parts used to construct or reconstruct the vehicle. Each bill of sale shall contain a description of the part, the manufacturer’s identification number of the part, if any, and the name, address, and telephone number of the seller.

400.16(2) *Procedures.* This subrule describes the procedures for obtaining department approval to title and register a specially constructed, reconstructed, street rod or replica motor vehicle. The procedures described are in addition to the regular procedures for titling and registering a vehicle.

a. The applicant shall apply to the county treasurer for a certificate of title and registration. The county treasurer, upon receiving an application that indicates the vehicle is a specially constructed, reconstructed, street rod or replica motor vehicle, shall forward the application to a motor vehicle investigator of the department.

b. The investigator shall contact the applicant and schedule a time and place for an examination of the vehicle and the ownership documents. The owner of the vehicle may drive or tow the vehicle to and from the examination location by completing an affidavit to drive on a form provided by the department. The form shall state that the vehicle is reasonably safe for operation and must be signed by the owner. The applicant, when appearing with the vehicle for the examination, shall submit to the investigator the ownership document for the vehicle, the ownership documents for essential parts, and a weigh ticket indicating the weight of the vehicle. However, a weigh ticket is not required for motorcycles, autocycles, trucks, truck tractors, road tractors or trailer-type vehicles.

c. If the investigator determines that the vehicle complies with 761—Chapter 450, that the integral parts and components have been identified as to ownership, and that the application has been completed properly:

(1) The investigator shall approve the application, affix to the vehicle an assigned vehicle identification number, and return the application and ownership documents to the applicant. The investigator shall authorize the county treasurer to issue a title and registration for the vehicle.

(2) If the vehicle is a passenger-type motor vehicle, the department shall determine its weight and value. The vehicle weight shall be fixed at the next even 100 pounds above the actual weight of the vehicle fully equipped, as provided in Iowa Code section 321.162. The weight and value shall constitute the basis for determining the annual registration fee under Iowa Code section 321.109, except as provided in Iowa Code section 321.113.

(3) The applicant shall then submit the ownership document for the vehicle to the county treasurer and continue with the regular title and registration process.

400.16(3) *Disapproval.* If the department determines that the vehicle does not comply with 761—Chapter 450, that the integral parts or components have not been identified as to ownership, or

that the application has not been completed properly, then the department shall not approve the vehicle for titling and registration.

400.16(4) Model year. The model year of a specially constructed or reconstructed motor vehicle is the year the vehicle is approved by the department as a specially constructed or reconstructed motor vehicle.

This rule is intended to implement Iowa Code sections 321.20, 321.23, 321.24, 321.52, 321.109 and 321.162.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.17(321) Remanufactured vehicle. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.18(321) Rescinded IAB 3/26/97, effective 4/30/97.

761—400.19(321) Temporary use of vehicle without plates or registration card.

400.19(1) Temporary use of vehicle without plates. A person who acquires a vehicle which is currently registered or in a dealer's inventory at the time of sale and who does not possess registration plates which may be assigned to and displayed on the vehicle may operate or permit the operation of the vehicle not to exceed 30 days from the date of purchase or transfer without registration plates displayed thereon, if ownership evidence is carried in the vehicle.

400.19(2) Temporary use of vehicle without registration card. A person who acquires a vehicle which is currently registered or in a dealer's inventory at the time of sale and who has possession of plates which may be attached to the vehicle acquired may operate or permit the operation of the vehicle not to exceed 45 days from the date of purchase or transfer without a registration card, if ownership evidence is carried in the vehicle.

400.19(3) Ownership evidence. Ownership evidence under this rule shall consist of the certificate of title or registration receipt, or a photocopy thereof, properly assigned to the person who has acquired the vehicle, or a bill of sale conveying ownership of the vehicle to the person who has acquired the vehicle. The ownership evidence shall be shown to any peace officer upon request.

This rule is intended to implement Iowa Code sections 321.25, 321.33 and 321.46.

761—400.20(321) Registration of motor vehicle weighing 55,000 pounds or more. When applying for registration or renewal of registration for a motor vehicle weighing 55,000 pounds or more, the owner shall present to the department or to the county treasurer proof of compliance with the federal heavy vehicle use tax required by 26 U.S.C. Section 4481 and 26 CFR Part 41.

400.20(1) If the motor vehicle is used exclusively in the transportation of harvested forest products, the owner may present a written statement certifying that usage and the usage will be recorded.

400.20(2) If the motor vehicle is used primarily for farming purposes, the owner may present a written statement certifying that usage and the usage will be recorded.

This rule is intended to implement Iowa Code sections 307.30 and 321.20.

761—400.21(321) Registration of vehicles on a restricted basis. The department may register a vehicle which does not meet the equipment requirements of Iowa Code chapter 321, due to the particular use for which it is designed or intended. Registration may be accomplished upon payment of the appropriate fees and after inspection and certification by the department that the vehicle is not in an unsafe condition.

400.21(1) Operation of the vehicle may be restricted to a roadway to which a specific lawful speed limit applies, as specified in Iowa Code section 321.285, if the maximum speed of the vehicle is such that the operation of the vehicle would impede or block the normal and reasonable movement of traffic.

400.21(2) The department may also restrict the operation of the vehicle to daylight hours if operation of the vehicle during hours other than daylight would create a hazard.

400.21(3) A certificate of restriction shall be issued in conjunction with registration of the vehicle, listing the restrictions that apply to the operation of the vehicle.

a. Registration laws applicable to motor vehicles in general shall also apply to vehicles registered under a restricted registration.

b. The department may approve exceptions to those equipment requirements of Iowa Code chapter 321 which cannot be met due to the particular use for which the vehicle is designed or intended.

400.21(4) The department shall not register an all-terrain vehicle. The department shall not register a vehicle built on or after January 1, 1968, unless it was manufactured primarily for use on public streets, roads and highways except a vehicle operated exclusively by a person with a disability, which may be registered if the department, in its discretion, determines that the vehicle is not in an unsafe condition. This subrule does not apply to a specially constructed, reconstructed, street rod or replica motor vehicle as defined in Iowa Code section 321.1.

This rule is intended to implement Iowa Code sections 321.1 and 321.234A and subsections 321.23(4), 321.30(2), and 321.101(1).

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.22(321) Transfers of ownership by operation of law. When ownership of a vehicle is transferred by operation of law under Iowa Code section 321.47, the following, in addition to rule 761—400.4(321), shall apply:

400.22(1) The new certificate of title and registration shall be issued, upon receipt of the proper documentation, by the county treasurer of the county where the transferee resides.

400.22(2) If the vehicle is not currently registered in this state, the registration fee and penalties due shall be computed in accordance with the following:

a. If the vehicle is ordered confiscated or forfeited by a court under a judgment or forfeiture, the fee shall be computed on the remaining unexpired months in the registration year from the date of the court order.

b. If the vehicle is sold on a peace officer's bill of sale as an unclaimed, stolen, embezzled or abandoned vehicle, or as a vehicle seized under Iowa Code section 321.84, the fee shall be computed on the remaining unexpired months in the registration year from the date of the sale.

c. If the vehicle is sold or transferred under a judgment or order entered by a court in a civil action or proceeding, or is transferred under any provision of Iowa Code section 321.47 which is not covered in this subrule, the fee shall include any delinquent fees which have accrued during previous registration periods and accrued penalties. Penalties shall continue to accrue until paid.

d. If the vehicle was last titled or registered in a foreign state, the fee shall be based on the month the vehicle becomes subject to registration in this state, except as provided in paragraphs 400.22(2) "a" and "b" above.

This rule is intended to implement Iowa Code sections 321.47, 321.105, 321.106, 321.134, and 321.135.

761—400.23(321) Junked vehicle.

400.23(1) *Junking certificate.* The owner of a vehicle that is to be junked or dismantled shall obtain a junking certificate in accordance with Iowa Code subsection 321.52(3).

400.23(2) *Retitling a junked vehicle.* The department may authorize issuance of a new certificate of title to the vehicle owner named on the junking certificate only if the department determines that the junking certificate was issued in error.

a. The reasons a junking certificate was issued in error include but are not limited to the following:

(1) The owner inadvertently surrendered the wrong certificate of title. The owner shall submit to the department a photocopy of the ownership document for each vehicle and a signed statement explaining the circumstances that resulted in the error.

(2) A junking certificate was obtained in error and the vehicle continues to be registered. The owner shall submit to the department a photocopy of the current registration and a signed statement explaining the circumstances that resulted in the error.

(3) The owner intended to apply for a salvage title under Iowa Code subsection 321.52(4) but inadvertently submitted an application for a junking certificate. The owner shall submit to the department

a bill of sale or other documentation from the previous owner stating that the vehicle was rebuildable when purchased and a signed statement explaining the owner's original intention to obtain a salvage title. The department shall inspect the vehicle to verify the rebuildable condition.

b. If the department determines that the junking certificate was issued in error, the department shall authorize the proper county treasurer to issue a certificate of title for the vehicle after payment by the owner of appropriate fees and taxes, including the return of any credit or refund for registration fees paid to the owner because of the error.

c. If the department determines that the junking certificate was not issued in error and denies the application for reinstatement of the certificate of title for the vehicle, the owner may apply for a certificate of title under the bonding procedure in rule 761—400.13(321) if the vehicle qualifies as an antique vehicle under Iowa Code subsection 321.115(1).

This rule is intended to implement Iowa Code subsection 321.52(3).

761—400.24(321) New vehicle registration fee. The registration fee shall be computed on the month of purchase of a new vehicle, except that the registration fee on a new vehicle acquired outside of this state shall be based on the month that the vehicle was brought into Iowa.

This rule is intended to implement Iowa Code sections 321.105 and 321.135.

761—400.25(321) Fees established by the department. If the department cannot obtain the retail list price and weight for a particular motor vehicle model registered under Iowa Code subsection 321.109(1), the department shall determine a list price and weight.

This rule is intended to implement Iowa Code sections 321.109, 321.157 and 321.159.

761—400.26(321) Anatomical gift. Voluntary contributions collected by the county treasurer or the department to the anatomical gift public awareness and transplantation fund shall be in whole dollar amounts. The county treasurer and the department shall remit contributions collected to the department of public health quarterly.

This rule is intended to implement Iowa Code section 321.44A.

761—400.27(321,322) Vehicles held for resale or trade by dealers. A motor vehicle dealer, as defined in Iowa Code section 321.1, is authorized to hold a motor vehicle for resale or trade under the following conditions.

400.27(1) Assignment to dealer. The certificate of title or manufacturer's certificate of origin for the vehicle shall be assigned to the dealer by the seller. The seller shall complete the assignment portion of the form, including the date of sale or trade and the name and address of the dealer, and shall sign the form. The date of the sale or trade shown in the assignment portion of the form shall be the date the dealer acquired the vehicle.

400.27(2) New certificate of title and registration not required.

a. A motor vehicle currently registered in Iowa may be held by a dealer without obtaining a new certificate of title or a new registration if the dealer holds for that vehicle a certificate of title or a manufacturer's certificate of origin properly assigned to the dealer.

b. A motor vehicle may also be held by a dealer without obtaining a new certificate of title or a new registration if the dealer has a title from a state that permits its titles to be reassigned by Iowa dealers and if a vacant reassignment space is available on the title.

400.27(3) New certificate of title required. A dealer shall obtain a new certificate of title, but is not required to pay registration fees for a vehicle if:

a. The vehicle has been registered in a foreign state or country that does not permit its titles to be reassigned by Iowa dealers.

b. The vehicle was assigned to the dealer using an affidavit of foreclosure form prescribed by the department or issued by a foreign jurisdiction.

c. The reassignment area of the certificate of title has been used.

d. Reserved.

e. The vehicle registration fee was delinquent in Iowa at the time the vehicle was acquired by the dealer. The delinquent fees and penalty shall be paid by the dealer from the first day the registration was due to the month the application for title is submitted.

f. In accordance with 761—Chapter 405, the dealer is required to obtain a salvage certificate of title.

400.27(4) *New certificate of title and registration fee required.* A dealer shall obtain both a new certificate of title and pay a registration fee for a vehicle if:

a. The vehicle has a foreign certificate of title but has never been registered and the dealer is not licensed under Iowa Code chapter 322 to sell that line-make of vehicle. The registration fee due shall be prorated for the remaining unexpired months of the dealer's registration year.

b. The vehicle was placed in storage by the previous owner. The registration fee due shall be a full registration year fee.

c. The vehicle has been registered in a foreign state or country that does not permit its titles to be reassigned by Iowa dealers or all reassignment spaces on the title are full and the application for a new certificate of title is submitted more than 30 days after the date the vehicle entered Iowa. The registration fee due shall be prorated for the remaining unexpired months of the dealer's registration year.

d. The vehicle was in the dealer's inventory and the dealer's license was revoked as provided in Iowa Code chapter 322 or 322C or surrendered in lieu of revocation. The dealer shall obtain title and registration within 30 days from the date of revocation or surrender of the license. The registration fee due shall be prorated for the remaining unexpired months of the registration year.

400.27(5) *Registration fee required.* A vehicle owned by a dealer and used as a work or service vehicle, or offered for lease, rent or hire, shall become subject to a registration fee in the month that the vehicle is first used for that purpose. The registration fee shall be due annually unless the vehicle is transferred to the dealer's inventory. To transfer the vehicle, the dealer shall surrender the registration plates that were issued for the vehicle.

400.27(6) *Violations.*

a. Failure to comply with this rule is a violation of Iowa Code subsection 321.104(2).

b. Failure to obtain a certificate of title when required shall result in a title penalty of \$10, as specified in Iowa Code subsection 321.49(1).

This rule is intended to implement Iowa Code sections 321.45, 321.46, 321.48, 321.49, 321.67, 321.70, 321.104 and chapter 322.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.28(321) *Special trucks.* The owner of a truck tractor registered as a special truck shall certify to the owner's county treasurer annually at the time of renewal that the truck tractor is not operated more than 15,000 miles annually.

This rule is intended to implement Iowa Code sections 321.1(75) and 321.121.

[ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.29(321) *Vehicles previously registered under Iowa Code chapter 326.* Rescinded IAB 11/23/05, effective 12/28/05.

761—400.30(321) *Registration of vehicles registered in another state or country.*

400.30(1) The registration fee for a vehicle from another state or country shall be due in the month that the vehicle becomes subject to registration in Iowa.

400.30(2) A vehicle registered in another state or country shall become subject to registration in Iowa and payment of the Iowa registration fee in:

a. The month of sale or transfer to an Iowa resident, or

b. The month that a nonresident owner establishes Iowa residency or accepts employment in Iowa of 90 days duration or longer. The county treasurer or the department may require from the applicant a written statement giving the date that the applicant established residency in Iowa.

400.30(3) Rescinded IAB 2/6/02, effective 3/13/02.

This rule is intended to implement Iowa Code sections 321.18, 321.20, 321.53 to 321.55, 321.101 and 321.135.

761—400.31 Rescinded, effective 12/1/83.

761—400.32(321) Vehicles owned by nonresident members of the armed services.

400.32(1) A vehicle owner who is a nonresident and a member of the armed services shall not be required to register the vehicle in Iowa if it is properly registered in the person's state of residence.

400.32(2) A vehicle owner who is a nonresident and a member of the armed services may register the vehicle in Iowa under the following conditions:

a. The vehicle is owned entirely by nonresidents.

b. The fee for a passenger-type vehicle registered under Iowa Code section 321.109 shall be based only on the weight of the vehicle; the part of the fee based on value shall be excluded. The fees for all other vehicles shall be determined as specified in Iowa Code chapter 321.

c. The application for vehicle registration shall include a certification by the person's commanding officer of the person's state of residence and assignment to Iowa.

400.32(3) If ownership of a passenger-type vehicle is transferred to another person, the vehicle shall be subject to registration in Iowa.

This rule is intended to implement Iowa Code sections 321.53 to 321.55 and 321.109.

761—400.33(321) Disabled veterans exemption from payment of registration fees. Rescinded IAB 11/23/05, effective 12/28/05.

761—400.34(321) Multipurpose vehicle registration fee. Rescinded IAB 11/7/07, effective 12/12/07.

761—400.35(321) Registration of vehicles equipped for persons with disabilities. The registration fee shall be reduced for an automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less with permanent equipment for assisting a person with a disability or for an automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less used by a person who uses a wheelchair as the person's only means of mobility. To qualify for the reduction, the owner of the vehicle must provide a written self-certification at the first registration and at each renewal:

400.35(1) That the automobile, multipurpose vehicle, or motor truck with an unladen weight of 10,000 pounds or less has permanently installed equipment manufactured for and necessary to assist a person with a disability, as defined in Iowa Code section 321L.1, to enter or exit the vehicle, or

400.35(2) That the owner or a member of the owner's household uses a wheelchair as the person's only means of mobility.

This rule is intended to implement Iowa Code sections 321.109, 321.124 and 321L.1.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—400.36(321) Land and water-type travel trailers registration fee. The registration fee for trailer-type vehicles designed to be used as a travel trailer and for use upon water shall be registered as a travel trailer. The exterior measurements used to determine the registration fee shall not include any pen deck area or area occupied by a trailer hitch.

This rule is intended to implement Iowa Code sections 321.1 and 321.123.

761—400.37(321) Motorcycle or autocycle primarily designed or converted to transport property. A motorcycle or autocycle primarily designed or converted to transport less than 1000 pounds of property shall be registered as a motorcycle or autocycle. A motorcycle or autocycle primarily designed or converted to transport 1000 pounds of property or more shall be registered as a motor truck.

This rule is intended to implement Iowa Code sections 321.1 and 321.117.

[ARC 2985C, IAB 3/15/17, effective 4/19/17]

761—400.38(321) Rescinded IAB 3/26/97, effective 4/30/97.

761—400.39(321) Conversion of motor vehicles.

400.39(1) An automobile converted to a truck with a carrying capacity of 1000 pounds or more shall be registered as a reconstructed motor vehicle.

400.39(2) A vehicle manufactured as a truck tractor or motor truck shall not be registered as a motor home unless the vehicle has been substantially altered to change its type and mode of operation so that it is a reconstructed vehicle as defined in Iowa Code section 321.1.

This rule is intended to implement Iowa Code sections 321.23, 321.111 and 321.124.
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.40(321) Manufactured or mobile home converted to or from real property.

400.40(1) *Conversion to real property.* When a manufactured or mobile home is converted to real property under Iowa Code section 435.26, the assessor shall collect its vehicle certificate of title. The assessor shall note the conversion on the face of the certificate of title above the assessor's signature, date the notation and deliver the title to the county treasurer. The county treasurer shall note the conversion on the vehicle record and then cancel and retain the certificate of title.

400.40(2) *Reconversion from real property.*

a. When a manufactured or mobile home is reconverted from real property by adding a vehicular frame, the owner may apply to the county treasurer for a certificate of title.

b. The owner shall submit a record of existing liens obtained from a local abstractor. The record shall identify the owner of the property, list all liens and encumbrances against the property, and shall be signed by the abstractor.

c. The owner shall also submit written consent to the reconversion from any person holding a mortgage on the real property (mortgagee). An existing mortgage shall be noted as a security interest on the certificate of title.

d. The county treasurer shall submit written notice of the reconversion to the county assessor's office.

This rule is intended to implement Iowa Code sections 321.1, 435.1, 435.26, 435.26A and 435.27.
[ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.41(321) Special registration plates. Rescinded IAB 3/1/95, effective 4/5/95.

761—400.42(321) Church bus registration fee. The church bus registration fee shall not apply if the bus is used in a manner other than provided by law or if ownership of the bus is transferred to a person who is not entitled to register the vehicle as a church bus.

400.42(1) When the church bus registration fee does not apply, the bus shall be registered under the provisions of Iowa Code section 321.122.

400.42(2) When Iowa Code section 321.122 applies and the bus is currently registered as a church bus, the registration fee shall be prorated for the remaining unexpired months of the registration year.

This rule is intended to implement Iowa Code sections 321.119 and 321.122.

761—400.43(321) Storage of vehicles.

400.43(1) The owner of a vehicle upon which the registration fee is not delinquent may surrender all registration plates for the vehicle to the county treasurer where the vehicle is registered and shall have the right to register the vehicle later upon payment of the annual registration fee due at the time of removal of the vehicle from storage. Payment of a registration fee shall not be required when the vehicle is removed from storage within the current registration year provided that registration fees have not been refunded. Plates that have been surrendered shall be destroyed. When a vehicle is removed from storage, the fee is \$5 for a set of replacement plates.

400.43(2) The owner of a motor vehicle which is placed in storage when the owner enters the military service of the United States shall comply with Iowa Code section 321.126, and subrule 400.43(1) does not apply.

This rule is intended to implement Iowa Code sections 321.126 and 321.134.
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.44(321) Penalty on registration fees.

400.44(1) *Monthly basis.* The penalty on the delinquent payment of a registration fee shall be computed on a monthly basis, rounded to the nearest whole dollar.

400.44(2) *Vehicle purchased.* The penalty on the registration fee shall accrue from the first day of the month following the date of purchase, unless the application for a certificate of title is submitted within 30 days after the date of purchase.

400.44(3) *Vehicle moved into Iowa.* The penalty on the registration fee shall accrue on the first day of the month following 30 days from the date a vehicle is moved into Iowa.

400.44(4) *When delinquency extends beyond the current year.* When the penalty on a delinquent registration fee extends beyond the current year, the penalty shall continue to accrue until paid. Penalty shall only accrue on the fee applicable at the time the delinquency accrued and shall not be applicable to subsequent registration fees which have not been paid.

400.44(5) *Statement of nonuse.* If the owner of a vehicle, on which the registration fees have not been paid for more than three complete registration years, certifies to the county treasurer of the owner's residence that the vehicle has not been moved or operated upon the highway since the year it was last registered, the county treasurer may register the vehicle upon payment of the current year's registration fee.

400.44(6) *Waiver of penalties for military members.* Registration penalties shall be waived as provided in Iowa Code section 321.134, subsection 5, if the owner provides a copy of an official government document verifying that the applicant is in the military service of the United States and has been relocated as a result of being placed on active duty on or after September 11, 2001.

This rule is intended to implement Iowa Code sections 321.39, 321.46, 321.47, 321.49, 321.134 and 321.135.

761—400.45(321) Suspension, revocation or denial of registration.

400.45(1) The department shall suspend or revoke registration and plates under Iowa Code section 321.101 when a written request is received from a peace officer or the county treasurer's office that issued the registration and plates.

a. A request from a peace officer shall be submitted on a form prescribed by the department.

b. A request from a county treasurer's office shall be signed by the county treasurer or designee.

400.45(2) When the registration of a vehicle has been revoked as provided in Iowa Code sections 321.101 and 321.101A, the registration fee and penalty shall accrue as if the plates had never been issued, unless waiver of registration fees and penalties is specifically provided for in Iowa Code chapter 321.

400.45(3) In accordance with Iowa Code section 252J.8, the department shall suspend or deny the issuance or renewal of registration and plates upon receipt of a certificate of noncompliance from the child support recovery unit.

a. The suspension or denial shall become effective 30 days after notice to the vehicle owner and continue until the department receives a withdrawal of the certificate of noncompliance from the child support recovery unit.

b. If a person who is the named individual on a certificate of noncompliance subsequently purchases a vehicle, the vehicle shall be titled and registered, but the registration shall be immediately suspended.

This rule is intended to implement Iowa Code sections 252J.1, 252J.8, 252J.9, 321.101, 321.101A and 321.127.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4758C, IAB 11/6/19, effective 12/11/19]

761—400.46(321) Termination of suspension of registration. Upon termination of the suspension of registration of a vehicle, the county treasurer shall issue new plates for the vehicle. If the new plates replace a current series of plates, there shall be a replacement fee as provided in Iowa Code section 321.42. If the vehicle is not currently registered at the time the suspension is lifted, the registration fee and penalties due shall be determined as follows:

400.46(1) If the registration fee was delinquent at the time that the suspension became effective, the penalty shall continue to accrue on the registration fee until the suspension became lifted and the registration fee is paid. In addition, if the suspension was for failure to pay an additional registration fee, the additional registration fee shall be paid before the suspension is lifted.

400.46(2) If the registration fee was not delinquent when the suspension became effective and the suspension is lifted after the beginning of another registration year, the annual registration fee for that year shall be due in the month the suspension is lifted. The penalty shall accrue on the registration fee the first day of the month following the month that the suspension was lifted. The annual registration fee on a recovered stolen vehicle for which the registration has been suspended shall be prorated for the remaining unexpired months of the registration year.

400.46(3) If the registration fee was not delinquent at the time that the suspension became effective and the suspension is lifted during the same registration period, no additional registration fees shall be due unless the suspension was for failure to pay an additional registration fee, in which event the additional registration fee shall be paid before the suspension is lifted.

This rule is intended to implement Iowa Code sections 321.42, 321.105 and 321.134.

761—400.47(321) Raw farm products. A vehicle may be operated with a gross weight of 25 percent in excess of the gross weight for which it is registered when transporting a load of raw farm products or soil fertilizers under Iowa Code section 321.466 except that nothing in this rule shall be construed to allow operation of a special truck on the public highways with a gross weight exceeding the maximum gross weight allowed under Iowa Code section 321.463(6). In addition, the following products shall be considered raw farm products. This list shall not be deemed conclusive and shall not exclude other commodities which might be considered raw farm products:

Animals which are dead	Hides
Berries, fresh	Honey, comb or extracted
Blood	Melons
Corn, ear corn including hybrids	Milk, raw
Corn, shelled	Nursery stock
Corn, cobs	Potatoes
Cream, separated	Peat
Eggs, fresh or frozen in shell	Poultry, live
Flax	Saw logs
Flaxseed	Sod
Fodder	Soybeans
Fruit, fresh	Straw, baled or loose
Grain, threshed or unthreshed	Vegetables, fresh
Hair	Wood, cord or stove wood
Hay, baled or loose	Wool

This rule is intended to implement Iowa Code sections 321.466(4) and 321.466(5).
[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.48(321) Special mobile equipment. Rescinded IAB 3/7/90, effective 4/11/90.

761—400.49(321) Special mobile equipment transported on a registered vehicle. Rescinded IAB 3/7/90, effective 4/11/90.

761—400.50(321,326) Refund of registration fees.

400.50(1) Vehicles registered by county treasurer.

a. The department shall refund fees for vehicles registered by the county treasurer pursuant to Iowa Code section 321.126.

b. A claim for refund shall be made on a form prescribed by the department. Except as provided in Iowa Code section 321.126, the claim may be submitted to the county treasurer's office in any county.

c. Registration plates shall be submitted with the claim if the vehicle is placed in storage or registered for apportioned registration, if the owner of the vehicle moves out of state, or if the plates have not been assigned to a replacement vehicle. If one or both plates have been lost or stolen, the claimant shall certify this fact in writing.

d. For a vehicle that was junked, the date on the junking certificate shall determine the date the vehicle was junked.

e. If the claim for refund is for excess credit or no replacement vehicle:

(1) The county treasurer shall enter into the state motor vehicle computer system the information required to process the refund. The information shall be entered within three days of receipt of the claim for refund.

(2) The claim for refund shall be approved or denied by the vehicle and motor carrier services bureau.

f. All other claims for refund shall be forwarded to the vehicle and motor carrier services bureau for processing.

400.50(2) Vehicles registered by department. Forms and instructions for claiming a refund on apportioned registration fees under Iowa Code section 326.15 may be obtained from the vehicle and motor carrier services bureau at the address in subrule 400.6(1). The claim for refund shall be filed at the same address.

This rule is intended to implement Iowa Code sections 25.1, 321.126 to 321.128 and 326.15.
[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.51(321) Assigned identification numbers. The department is authorized to issue to the owner an assigned vehicle identification number for a vehicle, an assigned component part number for a component part, and an assigned product identification number for a fence-line feeder, grain cart, or tank wagon. An identification number shall be assigned only if the department is satisfied as to the true identity and ownership of the vehicle, component part, fence-line feeder, grain cart or tank wagon. When an assigned vehicle identification number has been issued for a vehicle, the vehicle shall be registered and titled under that number. An assigned component part number or an assigned product identification number shall be used only for identification purposes.

400.51(1) Issuance of an identification number. The department shall issue an assigned vehicle identification number, assigned component part number or assigned product identification number, as applicable, only if:

a. The original number has been destroyed, removed or obliterated.

b. The vehicle has had a cab, body, or frame change and the replacement cab, body, or frame is within the manufacturer's interchangeability parts specifications catalog and is compatible with the make, model, and year of the vehicle. If the replacement cab, body, or frame change is not within the manufacturer's interchangeability parts specifications catalog or is not compatible with the make, year, and model of the vehicle, the vehicle shall be considered reconstructed and subject to rule 761—400.16(321).

c. The vehicle is a specially constructed, reconstructed, street rod or replica motor vehicle. See rule 761—400.16(321) for the requirements and procedures applicable to specially constructed, reconstructed, street rod or replica motor vehicles.

400.51(2) Procedures.

a. Request. Whenever an assigned identification number is required under subrule 400.51(1) and the request does not apply to a specially constructed, reconstructed, street rod or replica motor vehicle, the owner of the vehicle, component part, fence-line feeder, grain cart or tank wagon, or the person holding lawful custody, shall contact the department's bureau of investigation and identity protection at the address in subrule 400.6(2) and request the assignment of a number.

b. Examination. A motor vehicle investigator shall contact the owner and schedule a time and place for examination of the vehicle, component part, fence-line feeder, grain cart or tank wagon and ownership documents. The owner of the vehicle may drive or tow the vehicle to and from the examination location by completing the affidavit to drive section on the certification of compliance form. The affidavit shall state that the vehicle is reasonably safe for operation and must be signed by the owner.

If the vehicle has had a cab, body, or frame change, the owner shall have, for evidence of ownership for the replacement cab, body, or frame, a bill of sale with a description of the part, complete with the manufacturer's identification number, if any, and the name, address, and telephone number of the seller. The bill of sale, the vehicle, and the cab, body, or frame that has been replaced shall be made available for examination at the time and place scheduled.

c. Assigned vehicle identification number.

(1) The investigator upon approval of the request shall affix to the vehicle an assigned vehicle identification number and authorize the county treasurer to issue a title and registration for the vehicle.

(2) The owner shall submit the certificate of title and the registration receipt issued for the vehicle to the county treasurer. If the certificate of title is in the possession of a secured party, the county treasurer shall notify the secured party to return the certificate of title to the county treasurer for the purpose of issuing a corrected title. Upon receipt of the notification, the secured party shall submit the certificate of title within ten days. The county treasurer, upon receipt of the certificate of title and the registration receipt, shall issue a corrected title and registration receipt listing as the vehicle identification number the assigned vehicle identification number.

d. Assigned component part number. The investigator upon approval of the request shall affix to the component part an assigned component part number and give to the owner a component part form. The owner shall retain the form as a record of issuance and attachment. The form shall be made available on demand by any peace officer for examination.

e. Assigned product identification number. The investigator upon approval of the request shall affix an assigned product identification number to the fence-line feeder, grain cart or tank wagon and give to the owner an assigned product identification number form. The owner shall retain the form as a record of issuance and attachment. The form shall be made available on demand by any peace officer for examination.

400.51(3) Fees. A certificate of title fee and a fee for a notation of a security interest, if applicable, shall be collected by the county treasurer upon issuance of a corrected certificate of title. A corrected certificate of title shall not be required for a name change.

This rule is intended to implement Iowa Code sections 321.1, 321.43 and 321.92.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.52(321) Odometer statement.

400.52(1) Pursuant to Iowa Code section 321.71 and 49 U.S.C. Section 32705, an odometer disclosure statement shall be submitted with an application for certificate of title for a motor vehicle. The statement shall provide a current odometer reading and reflect whether the mileage is "actual," "not actual" or "exceeds mechanical limits."

400.52(2) If the transferor failed to provide an odometer disclosure statement or if the transferee lost the statement, and the transferee has attempted in good faith to contact the transferor to obtain a statement, the transferee may file a sworn statement of these facts on a form prescribed by the department. The sworn statement shall be accepted by the county treasurer or the department in lieu of the required odometer disclosure statement. The subsequent title issued from the sworn statement will record "not actual" mileage.

400.52(3) A model year formula for odometer statements shall be the current year minus ten. The resulting number represents the first model year for which a motor vehicle is exempt from the odometer statement requirements incident to a transfer.

This rule is intended to implement Iowa Code section 321.71.

761—400.53(321) Stickers.

400.53(1) *Placement of validation sticker.* The validation sticker shall be affixed to the lower left corner of the rear registration plate. EXCEPTIONS: For motorcycle, autocycle and small trailer plates, the validation sticker shall be affixed to the upper left corner of the plate. For natural resources plates, the sticker may be affixed to the lower right corner of the rear plate.

400.53(2) *Special fuel user identification sticker.* If the vehicle uses a special fuel as defined in Iowa Code section 452A.2, a special fuel user identification sticker shall be issued. This sticker shall be displayed on the cover of the fuel inlet of the motor vehicle or on the outside panel of the motor vehicle within 3 inches of the fuel inlet so as to be in view when fuel is delivered into the motor vehicle.

400.53(3) *Persons with disabilities parking sticker.* A persons with disabilities special registration plate parking sticker shall be affixed to the lower right corner of the rear registration plate.

400.53(4) *Special truck sticker.* An owner of a special truck, registered pursuant to Iowa Code section 321.121, who has been issued either regular registration plates or special registration plates other than special truck registration plates must obtain from the county treasurer a sticker which distinguishes the vehicle as a special truck. The sticker shall be affixed to the lower right corner of the rear registration plate. EXCEPTION: If the vehicle displays front and rear plates, two stickers shall be issued with one sticker affixed to the lower right corner of the front plate and rear plate. For natural resources plates, the stickers must be affixed to the lower left corner of the front and rear plates.

This rule is intended to implement Iowa Code sections 321.34, 321.40, 321.41, 321.121 and 321.166. [ARC 9833B, IAB 11/2/11, effective 12/7/11; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 3999C, IAB 9/12/18, effective 10/17/18]

761—400.54(321) Registration card issued for trailer-type vehicles. The registration card issued for trailer-type vehicles shall be carried in the vehicle which is described on the card or the registration card may be carried in the driver's compartment of the towing vehicle. If the registration card is carried in the vehicle which is described on such card, the registration card shall be enclosed in a registration card holder and the holder shall be attached to the vehicle so that the registration card may be viewed by any peace officer upon request.

This rule is intended to implement Iowa Code section 321.32.

761—400.55(321) Damage disclosure statement.

400.55(1) If the transferor failed to provide a damage disclosure statement or if the transferee lost the statement, and the transferee has attempted in good faith to contact the transferor to obtain a statement, the transferee may file a sworn statement of these facts. The transferee shall also complete section 2 of a separate damage disclosure statement and sign on the buyer's line. The sworn statement and damage disclosure statement completed by the transferee shall be accepted by the county treasurer or the department in lieu of the damage disclosure statement required from the transferor.

400.55(2) A model year formula for damage disclosure statements shall be the current year minus eight. The resulting number represents the first model year for which a motor vehicle is exempt from the damage disclosure statement requirements incident to a transfer.

This rule is intended to implement Iowa Code section 321.69.

761—400.56(321) Hearings. The department shall send notice by certified mail to a person whose certificate of title, vehicle registration, license, or permit is to be revoked, suspended, canceled, or denied. The notice shall be mailed to the person's mailing address as shown on departmental records and shall become effective 20 days from the date mailed. A person who is aggrieved by a decision of the department and who is entitled to a hearing may contest the decision in accordance with 761—Chapter 13. The request shall be submitted in writing to the director of the vehicle and motor carrier services

bureau at the address in subrule 400.6(1). The request for a contested case shall be deemed timely submitted if it is delivered or postmarked on or before the effective date specified in the notice of revocation, suspension, cancellation, or denial.

This rule is intended to implement Iowa Code sections 17A.10 to 17A.19, 321.101 and 321.102. [ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.57(321) Non-resident-owned vehicles. Rescinded IAB 2/6/02, effective 3/13/02.

761—400.58(321) Motorized bicycles. The following rules shall apply to motorized bicycles.

400.58(1) Maximum speed. If the department has reasonable cause to believe that a particular vehicle or model is capable of speeds exceeding 39 miles per hour, the department may conduct independent tests to determine the maximum speed of the vehicle or model. If the department determines that the maximum speed of the particular vehicle or model exceeds 39 miles per hour, the vehicle or model shall not be registered as a motorized bicycle.

400.58(2) Identification of a vehicle as a motorized bicycle. Registration plates issued for motorcycles shall also be issued for motorized bicycles.

This rule is intended to implement Iowa Code sections 321.1 and 321.166. [ARC 2887C, IAB 1/4/17, effective 2/8/17]

761—400.59(321) Registration documents lost or damaged in transit through the United States postal service. To obtain without cost the reissuance of registration documents that were sent by the county treasurer to the owner through the United States postal service and which were lost or damaged in transit, the owner of the vehicle shall file application for reissuance within 60 days of the date the documents were issued by the county treasurer.

This rule is intended to implement Iowa Code section 321.42.

761—400.60(321) Credit of registration fees.

400.60(1) Credit for unexpired registration fee. The applicant may claim credit, as specified in Iowa Code subsection 321.46(3), toward the registration fee for one newly acquired replacement vehicle.

a. The credit may be claimed only when the owner of the newly acquired vehicle is applying for a certificate of title and registration (or just registration if the vehicle is not subject to titling provisions) for the newly acquired vehicle.

b. For a junked vehicle, the date on the junking certificate shall determine the date the vehicle was junked.

c. Excess credit shall not be applied toward the registration fee for a second vehicle.

d. Credit shall be allowed for one or two vehicles which have been sold, traded or junked toward one replacement vehicle. Credit shall be based on the remaining unexpired months of the registration year(s) of the vehicle(s) sold, traded or junked.

400.60(2) Credit for transfer to spouse, parent or child. Credit shall be allowed toward a new registration for a vehicle being transferred to the applicant from the applicant's spouse, parent or child, or from a former spouse pursuant to a dissolution of marriage decree, if application for the certificate of title and registration (or just registration if the vehicle is not subject to titling provisions) is made within 30 days after the date of transfer. If the owner is deceased, credit may be transferred under rule 761—400.14(321) of this chapter.

400.60(3) Credit from/to apportioned registration.

a. Pursuant to Iowa Code section 321.46A, an owner may claim credit toward the registration fees due when changing a vehicle's registration from apportioned registration under Iowa Code chapter 326 to registration under Iowa Code chapter 321. The owner shall surrender proof of apportioned registration to the county treasurer. Credit shall be allowed for the unexpired complete calendar months remaining in the registration year from the date the application is filed with the county treasurer.

b. Pursuant to Iowa Code sections 321.126 and 321.127, the owner or lessee of a motor vehicle may claim credit for the apportioned registration fees due when changing the vehicle's registration from

registration by the county treasurer to apportioned registration. Application for apportioned registration shall be submitted to the department's vehicle and motor carrier services bureau; see 761—Chapter 500.

400.60(4) *Assignment of credit and registration plates from lessor to lessee.* When a lessee purchases the leased vehicle and within 30 days requests the assignment of the vehicle's fee credit and registration plates, the lessor shall assign the registration fee credit and registration plates for the purchased vehicle to the lessee.

This rule is intended to implement Iowa Code sections 321.46, 321.46A, 321.48, 321.126 and 321.127.

[ARC 3999C, IAB 9/12/18, effective 10/17/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—400.61(321) Reassignment of registration plates.

400.61(1) Registration plates may be reassigned if one of the owners listed on the registration receipt before the transfer is also a listed owner following the transfer.

400.61(2) Registration plates may be reassigned when credit is allowed toward a new registration for a vehicle being transferred to the owner's spouse, parent, or child, or to a former spouse pursuant to a dissolution of marriage decree. If the owner is deceased, plates may be transferred under rule 761—400.14(321).

400.61(3) Registration plates shall not be reassigned between a natural person or persons and a corporation, association, copartnership, company, or firm.

400.61(4) Registration plates may be reassigned and credit allowed if two or more corporations, associations, partnerships, or firms merge into one corporation, association, partnership or firm.

400.61(5) Registration plates may be assigned and credit allowed if an owner listed on the certificate of title and registration transfers ownership of the vehicle to a trust created by that owner.

This rule is intended to implement Iowa Code sections 321.34 and 321.46.

761—400.62(321) Storage of registration plates, certificate of title forms and registration forms. Registration plates, certificate of title forms and registration forms which are consigned to county treasurers by the department shall be stored in a secure location. The location may be within the office of the county treasurer which is accessible only to authorized persons or in a storage area located outside the general office area assigned to the county treasurer. Any storage area located outside the general office area assigned to the county treasurer shall be of the construction that it is accessible only to authorized persons, as designated by the county treasurer or department.

This rule is intended to implement Iowa Code sections 321.5, 321.8, and 321.167.

761—400.63(321) Disposal of surrendered registration plates. The county treasurer shall either destroy plates that have been surrendered to the county treasurer or return the surrendered plates to Iowa state industries for recycling.

This rule is intended to implement Iowa Code sections 321.5 and 321.171.

761—400.64(321) County treasurer's report of motor vehicle collections and funds. The county treasurer shall file the report provided for in Iowa Code section 321.153 in a manner prescribed by the department.

This rule is intended to implement Iowa Code section 321.153.

761—400.65 to 400.69 Reserved.

761—400.70(321) Removal of registration and plates by peace officer under financial liability coverage law. This rule applies to instances when a peace officer issues a citation and removes the registration receipt and registration plates of a motor vehicle registered in this state when the driver of the motor vehicle is unable to provide proof of financial liability coverage. This rule applies regardless of whether the vehicle was also impounded.

400.70(1) The peace officer shall forward the registration receipt and evidence of the violation to the county treasurer of the county in which the motor vehicle is registered. Evidence of the violation is one of the following:

a. A copy of the citation. The citation must either reference Iowa Code subparagraph 321.20B(4)“a”(3) or 321.20B(4)“a”(4), as applicable, or reference Iowa Code section 321.20B and indicate whether or not the vehicle was impounded.

b. A written statement from the peace officer listing the plate number of the registration plate removed from the vehicle and the vehicle owner’s name. The statement must either reference Iowa Code subparagraph 321.20B(4)“a”(3) or 321.20B(4)“a”(4), as applicable, or reference Iowa Code section 321.20B and indicate whether or not the vehicle was impounded. The statement must be signed by the peace officer or an employee of the law enforcement agency.

400.70(2) The peace officer may either destroy removed plates or deliver the removed plates to the county treasurer for destruction.

This rule is intended to implement Iowa Code section 321.20B.

761—400.71(321) Lemon law designation. Rescinded IAB 11/7/07, effective 12/12/07.

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[◇] Two or more ARCs

CHAPTER 425
MOTOR VEHICLE AND TOWABLE RECREATIONAL VEHICLE DEALERS,
MANUFACTURERS, DISTRIBUTORS AND WHOLESALERS

[Prior to 7/17/96, see 761—Chapters 420 and 422]

761—425.1(322) Introduction.

425.1(1) This chapter applies to the licensing of motor vehicle and towable recreational vehicle dealers, manufacturers, distributors and wholesalers. Also included in this chapter are the criteria for the issuance and use of dealer plates.

425.1(2) The vehicle and motor carrier services bureau administers this chapter. The mailing address is: Vehicle and Motor Carrier Services Bureau, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278.

a. Applications required by the chapter shall be submitted to the vehicle and motor carrier services bureau.

b. Information about dealer plates and the licensing of motor vehicles and towable recreational vehicle dealers, manufacturers, distributors and wholesalers is available from the vehicle and motor carrier services bureau or on the department's website at www.iowadot.gov.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.2 Reserved.

761—425.3(322) Definitions. The following definitions, in addition to those found in Iowa Code sections 322.2 and 322C.2, apply to this chapter of rules:

“Certificate of title” means a document issued by the appropriate official which contains a statement of the owner's title, the name and address of the owner, a description of the vehicle, a statement of all security interests, and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms “title certificate,” “title only” and “title” shall be synonymous with the term “certificate of title.”

“Consumer use” means use of a motor vehicle or towable recreational vehicle for business or pleasure, not for sale at retail, by a person who has obtained a certificate of title and has registered the vehicle under Iowa Code chapter 321.

“Dealer,” unless otherwise specified, means a person who is licensed to engage in this state in the business of selling motor vehicles or towable recreational vehicles at retail under Iowa Code chapter 322 or 322C.

“Engage in this state in the business” or similar wording means doing any of the following acts for the purpose of selling motor vehicles or towable recreational vehicles at retail: to acquire, sell, exchange, hold, offer, display, broker, accept on consignment or conduct a retail auction, advertise as being engaged in any of those acts, or to act as an agent for the purpose of doing any of those acts. A person selling at retail more than six motor vehicles or six towable recreational vehicles during a 12-month period may be presumed to be engaged in the business. See rule 761—425.20(322) for provisions regarding fleet sales and retail auction sales.

“Manufacturer's certificate of origin” means a certification signed by the manufacturer, distributor or importer that the vehicle described has been transferred to the person or dealer named, and that the transfer is the first transfer of the vehicle in ordinary trade and commerce. The terms “manufacturer's statement,” “importer's statement or certificate,” “MSO” and “MCO” shall be synonymous with the term “manufacturer's certificate of origin.” See rule 761—400.1(321) for more information.

“Principal place of business” means a building actually occupied where the public and the department may contact the owner or operator during regular business hours. In lieu of a building, a towable recreational vehicle dealer may use a manufactured or mobile home as an office if taxes are current or a towable recreational vehicle as an office if registration fees are current. The principal place of business must be located in this state.

“*Registered dealer*” means a dealer licensed under Iowa Code chapter 322 or 322C who possesses a current dealer certificate under Iowa Code section 321.59.

“*Regular business hours*” means to be consistently open to the public on a weekly basis at hours reported to the vehicle and motor carrier services bureau. Except as provided in Iowa Code section 322.36, regular business hours for a motor vehicle or towable recreational vehicle dealer shall include a minimum of 32 posted hours between 7 a.m. and 9 p.m., Monday through Friday.

“*Salesperson*” means a person employed by a motor vehicle or towable recreational vehicle dealer for the purpose of buying or selling vehicles.

“*Vehicle*,” unless otherwise specified, means a motor vehicle or towable recreational vehicle.

“*Wholesaler*” means a person who sells new vehicles to dealers and not at retail.

This rule is intended to implement Iowa Code chapters 322 and 322C.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 0778C, IAB 6/12/13, effective 7/17/13; ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.4 to 425.9 Reserved.

761—425.10(322) Application for dealer’s license.

425.10(1) *Application form.* To apply for a license as a motor vehicle or towable recreational vehicle dealer, the applicant shall complete an application on a form prescribed by the department.

425.10(2) *Surety bond.*

a. The applicant shall obtain a surety bond in the following amounts and file the original with the vehicle and motor carrier services bureau:

(1) For a motor vehicle dealer’s license, \$75,000. However, an applicant for a motor vehicle dealer’s license is not required to file a bond if the person is licensed as a towable recreational vehicle dealer under the same name and at the same principal place of business.

(2) For a towable recreational vehicle dealer’s license, \$75,000. However, an applicant for a towable recreational vehicle dealer’s license is not required to file a bond if the person is licensed as a motor vehicle dealer under the same name and at the same principal place of business.

b. The surety bond shall provide for notice to the vehicle and motor carrier services bureau at least 30 days before cancellation.

c. The vehicle and motor carrier services bureau shall notify the bonding company of any conviction of the dealer for a violation of laws related to the operations of the dealership.

d. If the bond is canceled, the vehicle and motor carrier services bureau shall notify the dealer by first-class mail that the dealer’s license shall be revoked on the same date that the bond is canceled unless the bond is reinstated or a new bond is filed.

e. If an applicant whose dealer’s license was revoked pursuant to paragraph 425.10(2) “*d*” establishes that the applicant obtained a reinstated or new bond meeting the requirements of this subrule that was effective on or before the date of cancellation, but due to mistake or inadvertence failed to file the original bond with the vehicle and motor carrier services bureau, the applicant may file the original of the reinstated or new bond. Upon filing, the department will rescind the revocation of the dealer’s license.

425.10(3) *Franchise.*

a. An applicant who intends to sell new motor vehicles or towable recreational vehicles shall submit to the vehicle and motor carrier services bureau a copy of a signed franchise agreement with the manufacturer or distributor of each make the applicant intends to sell.

b. If a signed franchise agreement is not available at the time of application, the department may accept written evidence of a franchise which includes all of the following:

(1) The name and address of the applicant and the manufacturer or distributor.

(2) The make of motor vehicle or towable recreational vehicle that the applicant is authorized to sell.

(3) The applicant’s area of responsibility as stipulated in the franchise and certified on a form prescribed by the department.

(4) The signature of the manufacturer or distributor.

c. Nothing in this subrule shall be construed to require a franchise agreement from a final-stage manufacturer applying for a motor vehicle dealer license under rule 761—425.11(322).

425.10(4) *Corporate applicants.* If the applicant is a corporation, the applicant shall certify on the application that the corporation complies with all applicable state requirements for incorporation.

425.10(5) *Principal place of business.* The applicant shall maintain a principal place of business, which must be staffed during regular business hours. See rules 761—425.12(322) and 761—425.14(322) for further requirements.

425.10(6) *Zoning.* The applicant shall provide to the vehicle and motor carrier services bureau written evidence, issued by the office responsible for the enforcement of zoning ordinances in the city or county where the applicant's business is located, which states that the applicant's principal place of business and any extensions comply with all applicable zoning provisions or are a legal nonconforming use.

425.10(7) *Separate licenses required.*

a. A separate license is required for each city or township in which an applicant for a motor vehicle dealer's license maintains a place of business.

b. A separate license is required for each county in which an applicant for a towable recreational vehicle dealer's license maintains a place of business.

425.10(8) *Financial liability.* The applicant for a motor vehicle dealer's license shall certify on the application that the applicant has the required financial liability coverage in the limits as set forth in Iowa Code subsection 322.4(1). It is the applicant's responsibility to ensure the required financial liability coverage is continuous with no lapse in coverage as long as the applicant maintains a valid dealer's license.

425.10(9) *Ownership information.*

a. If the owner of the business is an individual, the application shall include the legal name, bona fide address, and telephone number of the individual. If the owner is a partnership, the application shall include the legal name, bona fide address, and telephone number of two partners. If the owner is a corporation, the application shall include the legal name, bona fide address, and telephone number of two corporate officers. In all cases, the telephone number must be a number where the individual, partner, or corporate officer can be reached during normal business hours.

b. The application shall include the federal employer identification number of the business. However, if the business is owned by an individual who is not required to have a federal employer identification number, the application shall include the individual's social security number, Iowa nonoperator's identification number or Iowa driver's license number.

425.10(10) Reserved.

425.10(11) *Verification of compliance.* The department shall verify the applicant's compliance with all statutory and regulatory dealer licensing requirements.

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.11(322) Motor vehicle dealer licensing for final-stage manufacturers.

425.11(1) *Eligibility.* A final-stage manufacturer may be licensed as a motor vehicle dealer if the final-stage manufacturer:

a. Meets the definition of "final-stage manufacturer" in Iowa Code section 322.2.

b. Meets the requirements of a final-stage manufacturer in 49 CFR Section 567.5.

c. Is licensed as a manufacturer under Iowa Code chapter 322 and this chapter.

425.11(2) *Application.* A final-stage manufacturer shall apply for a motor vehicle dealer license in the manner described in rule 761—425.10(322) and shall certify that the final-stage manufacturer meets the eligibility requirements under subrule 425.11(1).

This rule is intended to implement Iowa Code sections 322.2 and 322.3.

[ARC 4343C, IAB 3/13/19, effective 4/17/19]

761—425.12(322) Motor vehicle dealer's principal place of business.

425.12(1) *Verification of compliance.* Before a motor vehicle dealer's license is issued, a representative of the department may physically inspect an applicant's principal place of business to verify compliance with this rule.

425.12(2) *Telephone service and office area.* A motor vehicle dealer's principal place of business shall include telephone service and an adequate office area, separate from other facilities, for keeping business records, manufacturers' certificates of origin, certificates of title or other evidence of ownership for all motor vehicles offered for sale. Telephone service must be a land line and not cellular phone service. Evidence of ownership may include a copy of an original document if the original document is held by a lienholder.

425.12(3) *Facility for displaying motor vehicles.* A motor vehicle dealer's principal place of business shall include a suitable space reserved for display purposes where motor vehicles may be viewed by prospective buyers. The facility shall be:

a. Within a building. EXCEPTION: For used motor vehicle dealers and for dealers selling new trucks or motor homes exclusively, the display facility may be an outdoor area with an all-weather surface. An all-weather surface does not include grass or exposed soil.

b. Of a minimum size.

(1) For display of motorcycles, motorized bicycles and autocycles, the minimum size of the display facility is 10 feet by 15 feet.

(2) For display of other motor vehicles, the minimum size of the display facility is 18 feet by 30 feet.

425.12(4) *Facility for reconditioning and repairing motor vehicles.* A motor vehicle dealer's principal place of business shall include a facility for reconditioning and repairing motor vehicles. The facility shall be an area that:

a. Is equipped to repair and recondition one or more motor vehicles of a type sold by the dealer.

b. Is within a building.

c. Has adequate access.

d. Is separated from the display and office areas by solid, floor-to-ceiling walls and solid, full-length doors.

e. Is of a minimum size.

(1) The minimum size facility for motorcycles, motorized bicycles and autocycles is an unobstructed rectangular area measuring 10 feet by 15 feet.

(2) The minimum size facility for other types of motor vehicles is an unobstructed rectangular area measuring 14 feet by 24 feet.

425.12(5) *Motor vehicle dealer who is also a recycler.* If a motor vehicle dealer also does business as a recycler, there shall be separate parking for motor vehicles being offered for sale at retail from motor vehicles that are salvage.

This rule is intended to implement Iowa Code sections 322.1 to 322.15.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0778C, IAB 6/12/13, effective 7/17/13; ARC 2985C, IAB 3/15/17, effective 4/19/17; ARC 4343C, IAB 3/13/19, effective 4/17/19]

761—425.13(321,322) Business records of a motor vehicle dealer with multiple licenses.

425.13(1) *Applicability.* A motor vehicle dealer licensed under Iowa Code chapter 322 and this chapter who holds more than one motor vehicle dealer license may maintain the dealer's collective business records together at any of the dealer's licensed locations.

425.13(2) *Separation of records.* Business records of licensed motor vehicle dealers kept at a single licensed location under this rule shall be stored separately and distinctly, in a manner distinguishable to each licensee, and shall not be commingled.

425.13(3) *Notification to the department.* A motor vehicle dealer shall notify the vehicle and motor carrier services bureau in writing no fewer than ten days before moving the dealer's business records to another licensed location.

This rule is intended to implement Iowa Code sections 321.63 and 322.2 to 322.15.

[ARC 4343C, IAB 3/13/19, effective 4/17/19; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.14(322) Towable recreational vehicle dealer's place of business.

425.14(1) Telephone service and office area. A towable recreational vehicle dealer's principal place of business shall include telephone service and an adequate office area, separate from other facilities, for keeping business records, manufacturers' certificates of origin, certificates of title or other evidence of ownership for all towable recreational vehicles offered for sale. Telephone service must be a land line and not cellular phone service. Evidence of ownership may include a copy of an original document if the original document is held by a lienholder.

425.14(2) Facility for displaying towable recreational vehicles. A towable recreational vehicle dealer's principal place of business shall include a space of sufficient size to permit the display of one or more towable recreational vehicles. The display facility may be an indoor area or an outdoor area with an all-weather surface. An all-weather surface does not include grass or exposed soil. If an outdoor display facility is maintained, it may be used only to display, recondition or repair towable recreational vehicles or to park vehicles.

425.14(3) Facility for repairing and reconditioning towable recreational vehicles. A towable recreational vehicle dealer's principal place of business shall include a facility for reconditioning and repairing towable recreational vehicles. The facility:

a. Shall be equipped and of sufficient size to repair and recondition one or more towable recreational vehicles of a type sold by the dealer.

b. Shall have adequate access.

c. May be an indoor area or an outdoor area with an all-weather surface. An all-weather surface does not include grass or exposed soil.

d. May occupy the same area as the display facility.

425.14(4) Towable recreational vehicle dealer also licensed as a motor vehicle dealer. If a towable recreational vehicle dealer is also licensed as a motor vehicle dealer under the same name and at the same principal place of business, separate facilities for displaying, repairing and reconditioning towable recreational vehicles are not required.

This rule is intended to implement Iowa Code sections 322C.1 to 322C.6.
[ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.15 and 425.16 Reserved.

761—425.17(322) Extension lot license. Extension lots of motor vehicle and towable recreational vehicle dealers must be licensed. Application to license an extension lot shall be made on a form prescribed by the department.

425.17(1) For a motor vehicle dealer, an extension lot is a car lot for the sale of motor vehicles that is located within the same city or township as, but is not adjacent to, the motor vehicle dealer's principal place of business.

425.17(2) For a towable recreational vehicle dealer, an extension lot is a towable recreational vehicle lot for the sale of towable recreational vehicles that is located within the same county as, but is not adjacent to, the towable recreational vehicle dealer's principal place of business.

425.17(3) An extension lot must be owned or leased by the dealer.

425.17(4) Parcels of property are adjacent if the parcels are owned or leased by the dealer and the parcels are either adjoining or are separated only by an alley, street or highway that is not a fully controlled access facility.

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.
[ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.18(322) Supplemental statement of changes. A motor vehicle dealer shall file a written statement with the vehicle and motor carrier services bureau at least ten days before any change of name, location, hours, or method or plan of doing business. A license is not valid until the changes listed in the statement have been approved by the vehicle and motor carrier services bureau.

This rule is intended to implement Iowa Code sections 322.1 to 322.15.
[ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.19 Reserved.

761—425.20(322) Fleet vehicle sales and retail auction sales.

425.20(1) Fleet sales. Any person who has acquired vehicles for consumer use in a business shall obtain the appropriate dealer's license when more than six vehicles are offered for sale at retail in a 12-month period.

425.20(2) Retail auction sales. Any person who sells at public auction more than six vehicles in a 12-month period shall obtain the appropriate dealer's license. All certificates of title for the vehicles offered for sale at public auction shall be duly assigned to the dealer.

425.20(3) Place of business. A dealer's license issued under this rule does not require a place of business.

425.20(4) Exceptions.

a. The state of Iowa, counties, cities and other governmental subdivisions are not required to obtain a dealer's license to sell their vehicles at retail.

b. This rule does not apply to a vehicle owner, or to an auctioneer representing the owner, selling vehicles at a retail auction if the vehicles were acquired by the owner for consumer use, the vehicles are incidental to the auction, and only one owner's vehicles are sold.

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.

761—425.21 to 425.23 Reserved.

761—425.24(322) Miscellaneous requirements.

425.24(1) The department shall not issue a license under Iowa Code chapter 322 or 322C to any other person at a principal place of business of a person currently licensed under Iowa Code chapter 322 or 322C.

425.24(2) A motor vehicle or towable recreational vehicle dealer shall not represent or advertise the dealership under any name or style other than the name which appears on the dealer's license.

425.24(3) Other business activities are allowed at a place of business of a dealer, but those activities shall not include the sale of firearms, dangerous weapons as defined in Iowa Code section 702.7, or alcoholic beverages as defined in Iowa Code subsection 123.3(4).

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.25 Reserved.

761—425.26(322) State fair, fairs, shows and exhibitions.

425.26(1) Definitions. As used in this rule:

"Community" means an area of responsibility as defined in Iowa Code section 322A.1.

"Display" means having new motor vehicles or new towable recreational vehicles available for public viewing at fairs, vehicle shows or vehicle exhibitions. The dealer may also post, display or provide product information through literature or other descriptive media. However, the product information shall not include prices, except for the manufacturer's sticker price. *"Display"* does not mean offering new vehicles for sale or negotiating sales of new vehicles.

"Fair" means a county fair or a scheduled gathering for a predetermined period of time at a specific location for the exhibition, display or sale of various wares, products, equipment, produce or livestock, but not solely new vehicles, and sponsored by a person other than a single dealer.

"Offer" new vehicles *"for sale," "negotiate sales"* of new vehicles, or similar wording, means doing any of the following at the state fair or a fair, vehicle show or vehicle exhibition: posting prices in addition to the manufacturer's sticker price, discussing prices or trade-ins, arranging for payments or financing, and initiating contracts.

"State fair" means the fair as discussed in Iowa Code chapter 173.

“*Vehicle exhibition*” means a scheduled event conducted at a specific location where various types, makes or models of new vehicles are displayed either at the same time or consecutively in time, and sponsored by a person other than a single dealer.

“*Vehicle show*” means a scheduled event conducted for a predetermined period of time at a specific location for the purpose of displaying at the same time various types, makes or models of new vehicles, which may be in conjunction with other events or displays, and sponsored by a person other than a single dealer.

425.26(2) *Permits for dealers of new motor vehicles.*

a. A “display only” fair, vehicle show or vehicle exhibition permit allows a motor vehicle dealer to display new motor vehicles at a specified fair, vehicle show or vehicle exhibition in any Iowa county. The permit is valid on Sundays.

b. A “full” fair, state fair, vehicle show or vehicle exhibition permit allows a motor vehicle dealer to display and offer new motor vehicles for sale and negotiate sales of new motor vehicles at the state fair, or a specified fair, vehicle show or vehicle exhibition that is held within the motor vehicle dealer’s community. EXCEPTION: A motor vehicle dealer who is licensed to sell motor homes may be issued a permit to offer for sale Class “A” and Class “C” motor homes at a specified fair, vehicle show or vehicle exhibition in any Iowa county. A “full” fair, show or exhibition permit is not valid on Sundays.

c. The following restrictions are applicable to both types of permits:

(1) Permits will be issued to motor vehicle dealers only for the state fair, fairs, vehicle shows or vehicle exhibitions where more than one motor vehicle dealer may participate.

(2) A permit is limited to the line makes for which the motor vehicle dealer is licensed in Iowa.

425.26(3) Reserved.

425.26(4) *Permits for dealers of new towable recreational vehicles.* A fair, vehicle show or vehicle exhibition permit allows a towable recreational vehicle dealer to display and offer new towable recreational vehicles for sale and negotiate sales of new towable recreational vehicles at a specified fair, vehicle show, or vehicle exhibition in any Iowa county.

a. The permit is valid on Sundays.

b. The permit is limited to the line makes for which the towable recreational vehicle dealer is licensed in Iowa.

c. A towable recreational vehicle dealer who does not have a permit may display vehicles at fairs, vehicle shows and vehicle exhibitions.

425.26(5) *Permit application.* A motor vehicle or towable recreational vehicle dealer shall apply for a permit on an application form prescribed by the department. The application shall include the dealer’s name, address and license number and the following information about the event: name, location, sponsor(s) and duration, including the opening and closing dates.

425.26(6) *Display of permit.* The motor vehicle or towable recreational vehicle dealer shall display the permit in close proximity to the vehicles being exhibited.

This rule is intended to implement Iowa Code sections 322.5(2) and 322C.3(9).

[ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.27 and **425.28** Reserved.

761—425.29(322) **Classic car permit.** A classic car permit allows a motor vehicle dealer to display and sell classic cars at a specified county fair, vehicle show or vehicle exhibition that is held in the same county as the motor vehicle dealer’s principal place of business. “Classic car” is defined in Iowa Code subsection 322.5(3).

425.29(1) The permit period is the duration of the event, not to exceed five days. The permit is valid on Sundays. Only one permit may be issued to each motor vehicle dealer for an event. No more than three permits may be issued to a motor vehicle dealer in any one calendar year.

425.29(2) Application for a classic car permit shall be made on a form prescribed by the department. The application shall include the dealer’s name, address and license number and the following

information about the county fair, vehicle show or vehicle exhibition: name, location, sponsor(s) and duration, including the opening and closing dates.

425.29(3) The motor vehicle dealer shall display the permit in a prominent place at the location of the county fair, vehicle show or vehicle exhibition.

This rule is intended to implement Iowa Code subsection 322.5(3).

761—425.30(322) Motor truck display permit. Application for a permit under Iowa Code subsection 322.5(4) shall be made on a form prescribed by the department. The application shall include information or documentation showing that the nonresident motor vehicle dealer is eligible for issuance of a permit and that the event meets the statutory conditions for permit issuance.

This rule is intended to implement Iowa Code subsection 322.5(4).

761—425.31(322) Firefighting and rescue show permit.

425.31(1) Application for a firefighting and rescue show permit shall be made on a form prescribed by the department. The application shall include the name, address and license number of the applicant, the type of vehicles being displayed, and the following information about the vehicle show or vehicle exhibition: name, location, sponsor(s), and duration, including the opening and closing dates.

425.31(2) The permit is not valid on Sundays. Only one permit shall be issued to each licensee for an event.

425.31(3) The permit holder shall display the permit in a prominent place at the location of the vehicle show or vehicle exhibition.

This rule is intended to implement Iowa Code section 322.5(5).

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18]

761—425.32 to 425.39 Reserved.

761—425.40(322) Salespersons of dealers.

425.40(1) Every motor vehicle and towable recreational vehicle dealer shall:

a. Keep a current written record of all salespersons acting in its behalf. The record shall be open to inspection by any peace officer or any employee of the department.

b. Maintain a current record of authorized persons allowed to sign all documents required under Iowa Code chapter 321 for vehicle sales.

425.40(2) No person shall either directly or indirectly claim to represent a dealer unless the person is listed as a salesperson by that dealer.

This rule is intended to implement Iowa Code sections 322.3, 322.13, and 322C.4.

[ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.41 to 425.49 Reserved.

761—425.50(322) Manufacturers, distributors, and wholesalers. This rule applies to the licensing of manufacturers, distributors, and wholesalers of new motor vehicles and towable recreational vehicles.

425.50(1) *Application for license.* To apply for a license, the applicant shall complete an application form prescribed by the department. A list of the applicant's franchised dealers in Iowa and a sample copy of a completed manufacturer's certificate of origin that is issued by the firm shall accompany the application. A distributor or wholesaler shall also provide a copy of written authorization from the manufacturer to act as its distributor or wholesaler.

425.50(2) *Licensing requirements.*

a. New motor homes delivered to Iowa dealers must contain the systems and meet the standards specified in Iowa Code section 321.1(36C) "d."

b. A licensee shall ensure that any new retail outlet is properly licensed as a dealer before any vehicles are delivered to the outlet.

c. A licensee shall notify the vehicle and motor carrier services bureau in writing at least ten days prior to any:

- (1) Change in name, location or method of doing business, as shown on the license.
- (2) Issuance of a franchise to a dealer in this state to sell new vehicles at retail.
- (3) Change in the trade name of a towable recreational vehicle manufactured for delivery in this state.

d. A licensee shall notify the vehicle and motor carrier services bureau in writing at least ten days before any new make of vehicle is offered for sale at retail in this state.

This rule is intended to implement Iowa Code sections 322.27 to 322.30 and 322C.7 to 322C.9. [ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.51(322) Factory or distributor representatives. Rescinded IAB 11/3/99, effective 12/8/99.

761—425.52(322) Used vehicle wholesalers. Rescinded IAB 11/7/07, effective 12/12/07.

761—425.53(322) Wholesaler's financial liability coverage. A new motor vehicle wholesaler shall certify on the license application that it has the required financial liability coverage in the limits set forth in Iowa Code section 322.27A. It is the wholesaler's responsibility to ensure that the required financial liability coverage is continuous with no lapse in coverage as long as the wholesaler maintains a valid wholesaler's license.

This rule is intended to implement Iowa Code section 322.27A.

761—425.54 to 425.59 Reserved.

761—425.60(322) Right of inspection.

425.60(1) Peace officers have the authority to inspect vehicles or component parts of vehicles, business records, and manufacturers' certificates of origin, certificates of title and other evidence of ownership for all vehicles offered for sale.

425.60(2) The department has the right at any time to verify compliance of a person licensed under Iowa Code chapter 322 or 322C or issued a certificate under Iowa Code section 321.59 with all statutory and regulatory requirements.

This rule is intended to implement Iowa Code sections 321.62, 321.95, 322.13, and 322C.1.

761—425.61 Reserved.

761—425.62(322) Denial, suspension or revocation.

425.62(1) The department may deny an application or suspend or revoke a certificate or license if the applicant, certificate holder or licensee fails to comply with the applicable provisions of this chapter of rules, Iowa Code sections 321.57 to 321.63 or Iowa Code chapter 322 or 322C.

425.62(2) The department may deny a dealer's application for the state fair or a fair, vehicle show or vehicle exhibition permit for a period not to exceed six months if the dealer fails to comply with the applicable provisions of rule 761—425.26(322) or Iowa Code section 322.5(2) or 322C.3(9).

425.62(3) The department may deny a motor vehicle dealer's application for a demonstration permit for a period not to exceed six months if the dealer fails to comply with rule 761—425.72(321).

425.62(4) The department shall send notice by certified mail to a person whose certificate, license or permit is to be revoked, suspended, canceled or denied. The notice shall be mailed to the person's mailing address as shown on departmental records or, if the person is currently licensed, to the principal place of business, and shall become effective 20 days from the date mailed. A person who is aggrieved by a decision of the department and who is entitled to a hearing may contest the decision in accordance with 761—Chapter 13. The request shall be submitted in writing to the director of the vehicle and motor carrier services bureau at the address in subrule 425.1(2). The request shall be deemed timely submitted

if it is delivered or postmarked on or before the effective date specified in the notice of revocation, suspension, cancellation or denial.

This rule is intended to implement Iowa Code chapter 17A and sections 321.57 to 321.63, 322.6, 322.9, 322.31, and 322C.6.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.63 to 425.69 Reserved.

761—425.70(321) Dealer plates.

425.70(1) Definition. The definitions of “dealer” and “vehicle” in Iowa Code section 321.1 apply to this rule.

425.70(2) Persons who may be issued dealer plates. Dealer plates as provided in Iowa Code sections 321.57 to 321.63 may be issued to:

- a. Licensed motor vehicle dealers.
- b. Licensed towable recreational vehicle dealers.
- c. A person engaged in the business of buying, selling or exchanging trailer-type vehicles subject to registration under Iowa Code chapter 321, other than towable recreational vehicles, and who has an established place of business for such purpose in this state.
- d. Insurers selling vehicles of a type subject to registration under Iowa Code chapter 321 solely for the purpose of disposing of vehicles acquired as a result of a damage settlement or recovered stolen vehicles acquired as a result of a loss settlement. The plates shall display the words “limited use.”
- e. Persons selling vehicles of a type subject to registration under Iowa Code chapter 321 solely for the purpose of disposing of vehicles acquired or repossessed by them in exercise of powers or rights granted by lien or title-retention instruments or contracts given as security for loans or purchase money obligations, and who are not required to be licensed dealers. The plates shall display the words “limited use.”
- f. Persons engaged in the business of selling special equipment body units which have been or will be installed on motor vehicle chassis not owned by them, solely for the purpose of delivering, testing or demonstrating the special equipment body and the motor vehicle. The plates shall display the words “limited use.”
- g. A licensed manufacturer of ambulances, rescue vehicles or fire vehicles, solely for the purpose of transporting, demonstrating, showing or exhibiting the vehicles. The plates shall display the words “limited use.”
- h. A licensed wholesaler who is also licensed as a motor vehicle dealer as specified in paragraph 425.70(3)“e.”

425.70(3) Use of dealer plates.

- a. Dealer plates shall not be displayed on vehicles that are rented or loaned. However, a dealer plate may be displayed on a motor vehicle, other than a truck or truck tractor, loaned to a customer of a licensed motor vehicle dealer while the customer’s motor vehicle is being serviced or repaired by the dealer.
- b. Saddle-mounted vehicles being transported shall display dealer plates.
- c. Dealer plates may be displayed on a trailer carrying a load, provided the motor vehicle towing the trailer is properly registered under Iowa Code section 321.109, 321.120, or 321.122, or is displaying a dealer plate described in paragraph 425.70(3) “e,” or a demonstration permit has been issued as described in rule 761—425.72(321).
- d. Dealer plates may be used by a dealer licensed as a wholesaler for a new motor vehicle model when operating a new motor vehicle of that model if the motor vehicle is owned by the wholesaler and is operated solely for the purpose of demonstration, show or exhibition.

e. A dealer plate issued under Iowa Code section 321.60 for the purpose of hauling a load or towing a trailer shall be marked “HAUL & TOW.” Dealer “HAUL & TOW” plates may only be displayed on vehicles in the dealer’s inventory that are continuously offered for sale at retail.

This rule is intended to implement Iowa Code sections 321.57 to 321.63.
[ARC 3687C, IAB 3/14/18, effective 4/18/18; ARC 4960C, IAB 3/11/20, effective 4/15/20]

761—425.71 Reserved.

761—425.72(321) Demonstration permits.

425.72(1) Demonstration permits may be issued by motor vehicle dealers to permit the use of dealer plates for the purpose of demonstrating the load capabilities of motor trucks and truck tractors. A demonstration permit must be issued on a form prescribed by the department.

425.72(2) The dealer shall complete the permit. The information to be filled out includes, but is not limited to, the following:

a. Date of issuance by the dealer, date of expiration, and the specific dates for which the permit is valid. The expiration date shall be five days or less from the date of issuance.

b. Dealer’s name, address and license number.

c. Name(s) of the prospective buyer(s) and all prospective drivers.

d. Route of the demonstration trip. The points of origin and destination shall be the dealership. The permit is not valid for a route outside Iowa.

e. The make, year and vehicle identification number of the motor vehicle being demonstrated.

425.72(3) The permit shall at all times be carried in the motor vehicle to which it refers and shall be shown to any peace officer upon request.

425.72(4) Only one demonstration permit per motor vehicle shall be issued for a prospective buyer.

425.72(5) The demonstration permit is valid only for a movement that does not exceed the legal length, width, height and weight restrictions. The permit is not valid for an overdimensional or overweight movement.

425.72(6) A dealer plate issued under Iowa Code section 321.60 for the purpose of hauling a load or towing a trailer may be used in lieu of a demonstration permit.

This rule is intended to implement Iowa Code sections 321.57 to 321.63.
[ARC 3687C, IAB 3/14/18, effective 4/18/18]

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[Filed ARC 0778C (Notice ARC 0658C, IAB 4/3/13), IAB 6/12/13, effective 7/17/13]
[Filed ARC 2985C (Notice ARC 2908C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]
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[Filed ARC 4343C (Notice ARC 4230C, IAB 1/16/19), IAB 3/13/19, effective 4/17/19]
[Filed ARC 4960C (Notice ARC 4770C, IAB 11/20/19), IAB 3/11/20, effective 4/15/20]

◇ Two or more ARCs

CHAPTER 511
SPECIAL PERMITS FOR OPERATION AND MOVEMENT OF
VEHICLES AND LOADS OF EXCESS SIZE AND WEIGHT

[Appeared as Ch 2, Highway Commission, 1973 IDR; amended in July 1974 and January and July 1975 Supplements]

[Previously numbered as (07,E) Ch 12, transferred at the request of the department on 10/8/75]

[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 2]

761—511.1(321E) Definitions. As used in this chapter, unless the context otherwise requires:

“*Compacted rubbish vehicle*” means any vehicle hauling rubbish that has been mechanically compacted with a hydraulic, electric, or air-operated ram.

“*Department*” means the Iowa department of transportation.

“*Dimensions*” or “*size*” means length, width or height limits.

“*Indivisible load*” means any load or vehicle exceeding applicable length or weight limits which, if separated into smaller loads or vehicles, would:

1. Compromise the intended use of the vehicle, i.e., make it unable to perform the function for which it was intended;
2. Destroy the value of the load or vehicle, i.e., make it unusable for its intended purpose; or
3. Require more than eight work hours to dismantle using appropriate equipment. The applicant for an indivisible load permit has the burden of proof as to the number of work hours required to dismantle the load.

“*Overdimensional*” or “*oversize*” means the exceeding of statutory length, width or height limits.

“*Permit*” means a permit issued under Iowa Code chapter 321E for the movement of an overdimensional or overweight vehicle, combination of vehicles, or vehicle with load. The term includes any additions or supplements thereto issued by the permit-issuing authority.

“*Permit-issuing authority*” means the:

1. Department’s vehicle and motor carrier services bureau for permits for movement on the primary road system.
2. Authority responsible for the maintenance of a nonprimary system of highways or streets for permits for movement on that system. However, the vehicle and motor carrier services bureau may issue single-trip permits on primary road extensions in cities in conjunction with movement on the rural primary road system.

“*Primary roads*” or “*primary road system*” is defined in Iowa Code section 306.3. The primary road system includes the interstate road system.

“*Raw forest products*” means the same as defined in Iowa Code section 321E.26.

“*Rubbish*” means any unwanted or useless material that has no commercial or practical value or use and that would normally be discarded.

“*Special or emergency situation*” means one or more of the following:

1. Circumstances where the movement is necessary to cooperate with cities, counties, other state agencies or other states in response to a national or other disaster.
2. Circumstances where the movement is necessary to cooperate with national defense officials.
3. Circumstances where the movement is necessary to cooperate with public or private utilities in order to maintain their public services.
4. Circumstances where the movement is essential to ensure safety and protection of any person or property due to an event such as, but not limited to, pollution of natural resources, a potential fire or an explosion.
5. Circumstances where weather or transportation problems create an undue hardship for citizens of the state of Iowa.
6. Circumstances where the movement involves emergency-type vehicles.
7. Uncommon or extraordinary circumstances where the movement is essential to the existence of an Iowa business and the move may be accomplished without causing undue hazards to the safety of the traveling public or undue damage to private or public property.
8. Other unique circumstances that warrant the issuance of a permit as determined by the permit-issuing authority.

“Statutory” when used with size or weight limits refers to those limits found in Iowa Code chapter 321.

This rule is intended to implement Iowa Code sections 321E.9, 321E.15, 321E.26, 321E.29, 321E.30 and 321E.34.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.2(321E) Location and general information.

511.2(1) Applications, forms, instructions and restrictions are available on the department’s website at www.iowadot.gov and by mail from the Vehicle and Motor Carrier Services Bureau, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3264; or by facsimile at (515)237-3257. Permits may be obtained electronically upon making application to the vehicle and motor carrier services bureau.

511.2(2) No overdimensional or overweight vehicle, combination of vehicles, or vehicle with load shall be moved on the highways of this state without permit except as provided in Iowa Code section 321.453.

511.2(3) Rescinded IAB 2/7/01, effective 3/14/01.

511.2(4) Except as provided in subrule 511.7(6) and rule 761—511.15(321,321E), permits may be issued only for the transporting of a single article which exceeds statutory size or weight limits or both, and which cannot reasonably be divided or reduced to statutory size and weight limits. However, permits may be issued for the transporting of property consisting of more than one article when:

- a. The statutory weight limits are not exceeded,
- b. One of the articles exceeds the statutory size limits, and
- c. The inclusion of other articles does not cause the statutory size limits to be exceeded by an additional amount.

511.2(5) Nothing in the permit shall be construed as waiving any load limits which have been or which might be established on any bridge or any road which is posted with embargo signs, unless specifically stated on the permit.

511.2(6) The state of Iowa, the department, and any other permit-issuing authority assume no responsibility for the property of the permit holder. Permit holders shall hold permit-issuing authorities harmless of any damages that may be sustained by the traveling public, adjacent property owners or the highways of this state on account of movements made under permit.

This rule is intended to implement Iowa Code sections 17A.3 and 321E.2.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.3(321E) Movement under permit.

511.3(1) During the movement of a vehicle or object under permit, the permit holder shall comply with the terms and conditions of the permit and shall take all reasonable precautions to protect and safeguard the lives and property of the traveling public and adjacent property owners.

511.3(2) Movement shall be made only when roads are clear of ice and snow and visibility is at least one-quarter mile. Snow removal equipment operating under permit is exempt from this restriction while snow removal operations are conducted. EXCEPTION: Nothing in this subrule shall be construed to mean that the movement of a compacted rubbish vehicle permitted under rule 761—511.11(321E) shall be subject to this restriction.

511.3(3) Movement shall be permitted only during the hours from one-half hour before sunrise to one-half hour after sunset unless it is established by the permit-issuing authority that the movement can be better accomplished at another period of time because of traffic volume conditions.

511.3(4) Except as provided in Iowa Code section 321.457, no movement shall be permitted on the holidays of Memorial Day, Independence Day and Labor Day, after 12 noon on days preceding these holidays and holiday weekends, during holiday weekends, or during special events when abnormally high traffic volumes can be expected. A holiday weekend occurs when the holiday falls on Friday, Saturday, Sunday or Monday. No movement shall be permitted until one-half hour before sunrise on the day after the holiday or holiday weekend.

511.3(5) Continuous moves. Vehicles and loads may travel by permit between one-half hour after sunset and one-half hour before sunrise if, in addition to the general provisions and general requirements specified by the permit, the following conditions are met.

- a. Dimensions shall not exceed:
 - (1) Width. 11 feet.
 - (2) Height. 14 feet, 6 inches.
 - (3) Length. 100 feet.
 - (4) Weight. Legal axle limits.
- b. Travel must be on roadways with a minimum width of 22 feet and minimum lane width of 11 feet.
- c. Safety lighting shall be provided at the widest part of a load. The lamps may be placed at the outer ends of the load itself or on appurtenances which are equal in width to the widest part of the load and positioned at both the extreme front and rear of the vehicle or trailer as follows:
 - (1) One lighted red lamp on each side at the rear of the load.
 - (2) One lighted yellow or amber lamp on each side at the front of the load.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.11.
 [ARC 3193C, IAB 7/5/17, effective 8/9/17]

761—511.4(321E) Permits. Permits issued shall be in writing or in electronic format and may be either single-trip, multitrip, annual, annual oversize/overweight, annual raw forest products, compacted rubbish or all-systems permits.

511.4(1) Methods of issuance.

- a. Permits for movement on the primary road system may be obtained in person, by facsimile, online, or by mail at the address in subrule 511.2(1).
- b. Reserved.

511.4(2) Forms.

- a. Applications for permits for movement on the primary road system shall be made online or on a form prescribed by the department.
- b. Any applications to other permit-issuing authorities made upon department forms shall be sufficient and accepted as properly made by these authorities.
- c. Subject to the preceding paragraph, permit-issuing authorities may adopt, amend or modify these forms provided that the amended or modified forms adequately identify the applicant, the hauling vehicle and load, the manner and extent that the vehicle with load exceeds the statutory size and weight limits, the route, and the authorization of the issuing authority. However, the load for a multitrip permit does not have to be identified but the vehicle and load cannot exceed either the weight per axle or the total weight identified on the multitrip permit. Axle spacings cannot change.

511.4(3) Validity.

- a. Annual, annual oversize/overweight, annual raw forest products, compacted rubbish, and all-systems permits shall expire one year from the date of issuance.
- b. A single-trip permit shall be effective for five days.
- c. The validity of a multitrip permit shall not exceed 60 calendar days.

511.4(4) Duplicate permit. If a permit is lost or destroyed before it has expired, a duplicate permit may be issued at the discretion of the permit-issuing authority. The expiration date on the duplicate permit shall be the same as on the original permit.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.3.
 [ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.5(321,321E) Fees and charges.

511.5(1) Annual oversize permit. A fee of \$50 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.8, payable prior to the issuance of the permit. Carriers purchasing annual permits in advance of use cannot return unused permits for refunds.

511.5(2) Annual oversize permit for certain divisible loads. A fee of \$25 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.29, payable prior to the issuance of the permit. Only divisible loads of hay, straw, stover, or bagged livestock bedding are permitted under this permit.

511.5(3) Annual raw forest products permit. A fee of \$175 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.26 for divisible loads of raw forest products, payable prior to the issuance of the permit.

511.5(4) Annual oversize/overweight permit. A fee of \$400 shall be charged for each annual oversize/overweight permit, payable prior to the issuance of the permit. Transfer of current annual oversize/overweight permit to a replacement vehicle may be allowed when the original vehicle has been damaged in an accident, junked or sold.

511.5(5) All-systems permit. A fee of \$160 shall be charged for each annual all-systems permit, payable prior to the issuance of the permit.

511.5(6) Bridge-exempt permit. A fee of \$25 shall be charged for each bridge-exempt permit issued pursuant to Iowa Code section 321E.7, payable prior to the issuance of the permit.

511.5(7) Multitrip permit. A fee of \$200 shall be charged for each multitrip permit, payable prior to the issuance of the permit.

511.5(8) Raw milk permit. A fee of \$25 shall be charged for each raw milk permit issued pursuant to Iowa Code section 321E.29A, payable prior to the issuance of the permit.

511.5(9) Single-trip permit. A fee of \$35 shall be charged for each single-trip permit, payable prior to the issuance of the permit.

511.5(10) Compacted rubbish permit. A fee of \$100 shall be charged for each compacted rubbish permit, payable prior to the issuance of the permit.

511.5(11) Duplicate permit. A fee of \$2 shall be charged for each duplicate permit, payable prior to the issuance of the permit.

511.5(12) Registration fee. A registration fee shall be charged for vehicles transporting buildings, except mobile homes and factory-built structures, on a single-trip basis. The vehicle shall be registered for the combined gross weight of the vehicle and load. The fee shall be 5 cents per ton exceeding the weight registered under Iowa Code section 321.122 per mile of travel and shall be payable prior to the issuance of the permit. Fees shall not be prorated for fractions of miles.

511.5(13) Fair and reasonable costs. Permit-issuing authorities may charge any permit applicant:

a. A fair and reasonable cost for the removal and replacement of natural obstructions or official signs and signals.

b. A fair and reasonable cost for measures necessary to avoid damage to public property including structures and bridges.

511.5(14) Methods of payment. Fees and costs required under this chapter shall normally be paid by credit card, certified check, cashier's check, traveler's check, bank draft or cash. Personal checks may be accepted at the discretion of the permit-issuing authority.

This rule is intended to implement Iowa Code sections 321.12, 321.122, 321E.14, 321E.29, 321E.29A and 321E.30.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.6(321E) Insurance and bonds.

511.6(1) Insurance.

a. Public liability insurance in the amounts of \$100,000 bodily injury each person, \$200,000 bodily injury each occurrence, and \$50,000 property damage with an expiration date to cover the tenure of the annual, annual oversize/overweight, annual raw forest products, all-systems, multitrip or single-trip permit shall be required. In lieu of filing with the permit-issuing authority, a copy of the current certificate of public liability insurance in these amounts shall be carried in the vehicle for which the permit has been issued. Proof of liability insurance may be either in writing or in electronic format.

b. Notwithstanding paragraph "a" of this subrule, a carrier may act as a self-insurer if an application for self-insurance is filed with and approved by the department.

511.6(2) Bond.

a. The permit-issuing authority may require the applicant to file a bond, certified check or other assurance in an amount sufficient to cover the reasonably anticipated cost of damage or loss to private property, either real or personal, likely to be caused by or arising out of the movement of the vehicle and load or to ensure compliance with permit provisions.

b. The amount in the preceding paragraph may be reduced either in whole or in part by the applicant's submission to the permit-issuing authority of written permission from an affected third party stating in substance that the third party either owns or has the right of exclusive possession and control over the affected property, does by the party's signature consent to the move and that the applicant has in hand paid or secured the payment of the anticipated cost of loss or damage to the party's property.

This rule is intended to implement Iowa Code section 321E.13.
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.7(321,321E) Annual permits. Annual permits are issued for indivisible vehicles or indivisible loads for travel when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The owner or operator shall select a route using the vertical clearance map and road construction and travel restrictions map provided by the department. Detour and road embargo information may also be found online at: www.511ia.org. Prior to making the move, the owner or operator shall contact the department by telephone at (515)237-3264 between 8 a.m. and 4:30 p.m., Monday through Friday, except for legal holidays, to verify that the owner or operator is using the most recent information. Annual permits are issued for the following:

511.7(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 12 feet 5 inches including appurtenances.
- b. *Length.* 120 feet 0 inches overall.
- c. *Height.* 13 feet 10 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Movement is allowed for unlimited distance; routing through the vehicle and motor carrier services bureau is not required.

511.7(2) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 14 feet 6 inches.
- b. *Length.* 120 feet 0 inches overall.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the vehicle and motor carrier services bureau or the route continues on at least four-lane roads. Trip routes are valid for five days.

511.7(3) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 16 feet 0 inches.
- b. *Length.* 120 feet 0 inches.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Trip routes must be obtained from the vehicle and motor carrier services bureau.

511.7(4) Rescinded IAB 1/23/02, effective 2/27/02.

511.7(5) Truck trailers manufactured or assembled in the state of Iowa provided the following are met:

- a. *Width.* Not to exceed 10 feet 0 inches.
- b. *Length.* Overall combination length must comply with Iowa Code section 321.457.
- c. *Height.* Statutory: Not to exceed 13 feet 6 inches.
- d. *Weight.* See rule 761—511.14(321,321E).

- e. *Speed.* Rescinded IAB 2/7/01, effective 3/14/01.
- f. *Roadway width.* At least 24 feet 0 inches.
- g. *Limited movement.* Movement shall be solely for the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and shall be on the most direct route necessary for the movement.

511.7(6) Vehicles with divisible loads of hay, straw, stover, or bagged livestock bedding provided the following are not exceeded:

- a. *Width.* 12 feet 5 inches.
- b. *Length.* Statutory: 75 feet.
- c. *Height.* Statutory: 14 feet 6 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Unlimited.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10, 321E.29 and 321E.29A.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.8(321,321E) Annual oversize/overweight permits. Annual oversize/overweight permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. Travel is not allowed on the interstate. However, a carrier moving under this annual oversize/overweight permit may operate under the same restrictions as an annual permit under rule 511.7(321,321E) when the vehicle meets the dimensions required by that rule. Routing is subject to embargoed bridges and roads and posted speed limits. Annual oversize/overweight permits are issued for the following:

511.8(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 13 feet 5 inches.
- b. *Length.* 120 feet 0 inches.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Routing.* The owner or operator shall select a route using a vertical clearance map, bridge embargo map, pavement restrictions map, and construction and travel restrictions map provided by the department. Detour and road embargo information may be found online at www.511ia.org. The owner or operator shall contact the department by telephone at (515)237-3264 between 8 a.m. and 4:30 p.m., Monday through Friday, except for legal holidays, prior to making the move to verify that the owner or operator is using the most recent information.

511.8(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8 and 321E.9.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.9(321,321E) All-systems permits. All-systems permits are issued by the vehicle and motor carrier services bureau for indivisible vehicles or indivisible loads for travel on the primary road system and specified city streets and county roads when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The vehicle and motor carrier services bureau will provide a list of the authorized city streets and county roads. Permit holders shall consult with local officials when traveling on county roads or city streets for bridge embargo, vertical clearance, detour, and road construction information. These permits are issued for the following:

511.9(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 12 feet 5 inches including appurtenances.
- b. *Length.* 120 feet 0 inches overall.
- c. *Height.* 13 feet 10 inches.

- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Movement is allowed for unlimited distance; routing through the vehicle and motor carrier services bureau and city and county jurisdictions is not required.

511.9(2) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 14 feet 6 inches.
- b. *Length.* 120 feet 0 inches overall.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the vehicle and motor carrier services bureau and city and county jurisdictions or the route continues on at least four-lane roads. Trip routes are valid for five days.

511.9(3) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 16 feet 0 inches.
- b. *Length.* 120 feet 0 inches.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Trip routes must be obtained from the vehicle and motor carrier services bureau and city and county jurisdictions.

511.9(4) Rescinded IAB 1/23/02, effective 2/27/02.

511.9(5) Truck trailers manufactured or assembled in the state of Iowa provided the following are met:

- a. *Width.* Not to exceed 10 feet 0 inches.
- b. *Length.* Overall combination length must comply with Iowa Code section 321.457.
- c. *Height.* Statutory: Not to exceed 13 feet 6 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Speed.* Rescinded IAB 2/7/01, effective 3/14/01.
- f. *Roadway width.* At least 24 feet 0 inches.
- g. *Limited movement.* Movement shall be solely for the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and shall be on the most direct route necessary for the movement.

511.9(6) Vehicles with divisible loads of hay, straw, stover, or bagged livestock bedding provided the following are not exceeded:

- a. *Width.* 12 feet 5 inches.
- b. *Length.* Statutory: 75 feet.
- c. *Height.* Statutory: 14 feet 6 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Movement is allowed for unlimited distance; routing through the vehicle and motor carrier services bureau and city and county jurisdictions is not required.

511.9(7) Necessary trip routes must be obtained from the appropriate city and county jurisdictions.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10 and 321E.29.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.10(321,321E) Multitrip permits. Multitrip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit shall be for unlimited trips along a specific route between one point of origin and one point of destination. Additional routes will require a new permit. Multitrip permits are issued for the following:

511.10(1) Multitrip permits may be issued for vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

- a. *Width.* 16 feet.
- b. *Length.* 120 feet.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* 156,000 pounds total gross weight.
- e. *Distance.* On routes specified by the permit-issuing authority.

511.10(2) Multitrip permits may be issued for all movements allowed under the single-trip permit provisions of rule 761—511.12(321,321E) provided the movement is within the size and weight limitations of subrule 511.10(1).

511.10(3) The dimensions listed on the permit are considered maximums. The movement is legal as long as the vehicle and load do not exceed these dimensions and the movement meets all other requirements of Iowa Code chapter 321E and this chapter of rules.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3 and 321E.9A.

[ARC 3193C, IAB 7/5/17, effective 8/9/17]

761—511.11(321E) Compacted rubbish vehicle permits. All compacted rubbish vehicle permits issued by the department shall be subject to the following:

511.11(1) Permits issued shall be in writing or in an electronic format, shall be carried in the vehicle for which the permit has been issued and shall be available for inspection by any peace officer or authorized agent of any permit-granting authority.

511.11(2) Movements by permit shall be allowed day and night, seven days a week including holidays.

511.11(3) Vehicles traveling under permit shall be registered for the gross weight or combined gross weight of the vehicle and load.

511.11(4) Vehicles under permit must be in compliance with posted bridge and road embargoes and speed limits.

511.11(5) Maximum axle weight allowed on the interstate system shall be 20,000 pounds on a single axle and 34,000 pounds on a tandem axle.

This rule is intended to implement Iowa Code section 321E.30.

[ARC 3193C, IAB 7/5/17, effective 8/9/17]

761—511.12(321,321E) Single-trip permits. Single-trip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit shall be for a specific route between an origin and destination. Single-trip permits are issued for the following:

511.12(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* Limited to the maximum physical limitations and clearances of the roadway and infrastructure along the intended route of travel.

b. *Length.* Limited to the maximum physical limitations and clearances of the roadway along the intended route of travel.

c. *Height.* Limited only to the height of underpasses, bridges, power lines, and other established height restrictions. The carrier shall be required to contact affected public utilities when the height of the vehicle with load exceeds 16 feet 0 inches. At the discretion of the permit-issuing authority, a written verification may be required from the affected utility.

d. *Weight.* See rule 761—511.14(321,321E).

e. *Distance.* Limited at the discretion of the permit-issuing authority. The following factors shall be considered:

Road conditions; road width; traffic volume; weather conditions; and roadside obstructions, including bridges, signs and overhead obstructions.

511.12(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.9 and 321E.29.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.13(321,321E) Annual raw forest products permits. Annual raw forest products permits are issued for vehicles transporting divisible loads of raw forest products when the weight exceeds statutory limits. Travel is not allowed on the interstate. The owner or operator shall select a route using the vertical clearance map, bridge embargo map, pavement restrictions map, and construction and travel restrictions map provided by the department. The owner or operator must contact the appropriate local authority for route approval to use this permit on county roads or city streets. Detour and road embargo information may be found online at: www.511ia.org. Routing is subject to embargoed bridges and roads and posted speed limits. Annual raw forest products permits are issued for the following:

511.13(1) Vehicles with divisible loads of raw forest products provided the following are not exceeded:

- a. *Width.* Statutory: 8 feet 6 inches.
- b. *Length.* Limited to the maximum dimensions in Iowa Code section 321.457.
- c. *Height.* Statutory: 13 feet 6 inches.
- d. *Weight.* See rule 761—511.14(321,321E).
- e. *Distance.* Unlimited.

511.13(2) Reserved.

This rule is intended to implement Iowa Code sections 321.463, 321E.2, 321E.3 and 321E.26.
[ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.14(321,321E) Maximum axle weights and maximum gross weights for vehicles and loads moved under permit.

511.14(1) *Annual and all-systems permits.*

a. For movement under an annual or all-systems permit, the axle weight and combined gross weight shall not exceed the limits found in Iowa Code section 321.463(3).

b. See subrule 511.14(5) for exceptions for special mobile equipment.

511.14(2) *Annual oversize/overweight permits or annual raw forest products permits.*

a. For movement under an annual oversize/overweight permit or an annual raw forest products permit, the gross weight on any axle shall not exceed 20,000 pounds, with a maximum of 156,000 pounds total gross weight.

b. See subrule 511.14(5) for exceptions for special mobile equipment.

511.14(3) *Multitrip permits.*

a. For movement under a multitrip permit, the gross weight on any axle shall not exceed 20,000 pounds with a maximum of 156,000 pounds total gross weight.

b. See subrule 511.14(5) for exceptions for special mobile equipment.

511.14(4) *Single-trip permits.*

a. For movement under a single-trip permit, the gross weight on any axle shall not exceed 20,000 pounds.

b. If the combined gross weight exceeds 100,000 pounds, a single-trip permit may be issued for the movement only if the permit-issuing authority determines that it would not cause undue damage to the road and is in the best interest of the public.

c. Cranes may have a maximum of 24,000 pounds per axle for movement under a single-trip permit. Routes must be reviewed by the permit-issuing authority prior to issuance.

d. See subrule 511.14(5) for exceptions for special mobile equipment.

511.14(5) *Special mobile equipment.* Special mobile equipment may have a gross weight of 36,000 pounds on any single axle equipped with minimum size 26.5-inch by 25-inch flotation pneumatic tires and a maximum gross weight of 20,000 pounds on any single axle equipped with minimum size 18-inch by 25-inch flotation pneumatic tires, provided that the total gross weight of the vehicle or a combination of vehicles does not exceed a maximum of 80,000 pounds for movement under an annual or all-systems

permit and 126,000 pounds for movement under a single-trip, multitrip or annual oversize/overweight permit.

For tire sizes and weights allowed between the maximum and minimum indicated, the following formula shall apply: Axle weight = 20,000 pounds + (tire width - 18) × 1,882 pounds.

511.14(6) Permitted tandem axle weights.

a. Vehicles operating under an annual oversize permit, annual oversize/overweight permit, annual raw forest products permit, single-trip permit, or multitrip permit may have a gross weight not to exceed 46,000 pounds on a single-tandem axle of the truck tractor and a gross weight not to exceed 46,000 pounds on a single-tandem axle of the trailer or semitrailer if each axle of each tandem group has at least four tires.

b. The maximum weight of any single axle within a permitted tandem axle group shall be 24,000 pounds.

c. A permitted tandem axle shall not be a part of a larger group of axles whose centers are greater than 96 inches apart.

This rule is intended to implement Iowa Code sections 321.463, 321E.7, 321E.8, 321E.9, 321E.9A, 321E.26 and 321E.32.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4345C, IAB 3/13/19, effective 4/17/19; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.15(321,321E) Movement of vehicles with divisible loads exceeding statutory size or weight limits.

511.15(1) Vehicles with divisible loads exceeding statutory size or weight limits may be moved under a single-trip permit if the permit-issuing authority determines that a special or emergency situation warrants its issuance.

511.15(2) At the discretion of the permit-issuing authority, the combined gross weight may exceed the statutory weight, but the axle weights shall be subject to rule 761—511.14(321,321E).

511.15(3) Movement shall be subject to the routes established by the permit-issuing authority.

511.15(4) This rule does not apply to divisible loads of hay, straw, stover or bagged livestock bedding.

This rule is intended to implement Iowa Code sections 321.463 and 321E.29.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.16(321E) Towing units. The towing unit shall be a truck or truck tractor with dual wheels and with a gross vehicle weight rating of at least 10,000 pounds when towing mobile homes or loads exceeding 10,000 pounds.

This rule is intended to implement Iowa Code section 321.457.

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.17(321E) Escorting.

511.17(1) Escort qualification. An escort shall be a person aged 18 or over who possesses a valid driver's license which allows driving unaccompanied and who carries proof of public liability insurance in the amounts of \$100,000/\$200,000/\$50,000.

511.17(2) Escorting responsibilities.

a. The escorting vehicle shall be a mid-size automobile or motor truck with sufficient mobility to be able to assist in an emergency and designed to afford clear and unobstructed vision both front and rear. The escorting vehicle shall not be used to tow a trailer while performing escorting duties. In questionable cases the permit-issuing authority shall determine if a vehicle meets these conditions.

b. The escorting vehicle shall have a flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning. While escorting a permit load, the light shall be mounted on top of the escort vehicle and shall be burning. Additional escort vehicle markings may be approved or required by the permit-issuing authority.

c. An 18-inch by 18-inch red or orange fluorescent flag shall be mounted on each corner of the front bumper of the escort vehicle.

d. The escort shall remain a distance of approximately 300 feet in front or to the rear of the load. However, when traveling within the corporate limits of a city, the escort shall maintain a reasonable and proper distance consistent with existing traffic conditions.

e. A separate escort shall be provided for each load hauled under escort.

f. All traffic laws and provisions of the oversize permit for the load shall be obeyed.

g. The escort shall not assume responsibility for stopping traffic. An on-duty peace officer, as defined in Iowa Code section 321.1, shall be contacted to provide any traffic control needed.

h. Immediately prior to an escorting trip, the escort shall determine that the escorting vehicle is in a safe operational condition and that the dimensions of the vehicle and load are in compliance with the permit issued.

i. Escort fees charged by state and local authorities shall not exceed \$250 per day per escort vehicle.

j. A pole used for measuring vertical clearances shall be mounted on the front escort vehicle. The escort shall be required to measure all vertical clearances whenever the height of the permitted vehicle exceeds 14 feet 6 inches up to and including 20 feet.

511.17(3) Requirements for escorts, flags, signs and lights. The following chart explains the minimum escort and warning devices required for vehicles operating under permit.

**Minimum Warning Devices and Escort Requirements
For Vehicles Operating Under Permit**

	Flags/Signs	Lights	Escorts	
			4-Lane	2-Lane
Length				
75'1" up to and including 85'	yes	not required	not required	not required
Over 85' up to and including 120'	yes	yes	not required	not required
Over 120'	yes	not required	rear	rear
Projections				
Front: over 25'	not required	yes	not required	not required
Rear: over 4' up to and including 10'	flags only	not required	not required	not required
Rear: over 10'	flags only	yes	not required	not required
Height				
Over 14'6" up to and including 20'	yes	not required	front with a height pole	front with a height pole
Weight				
Over 80,000 lbs.	not required	yes	not required	not required
Width				
Over 8'6" up to 12'0"	yes	not required	not required	not required
Over 12'0" up to and including 14'6"	yes	not required	rear *	front *
Over 14'6" up to and including 16'6"	yes	not required	rear *	front
Over 16'6" up to and including 18'	yes	not required	rear	front

*In lieu of an escort, a carrier can display an amber light or strobe light on the power unit and on the rear extremity of the vehicle or load.

yes = required

Definitions:

Flags - Red or orange fluorescent flags at least 18" square must be mounted as follows: one flag at each front corner of the towing unit and one flag at each rear corner of the load. In addition, there must be a flag at any additional protrusion in the width of the load.

Signs - A sign reading "Oversize Load" must be used. The sign must be at least 18" high by 7' long with a minimum of 10" black letters, with a 1½" stroke, on a yellow background, and mounted on the front bumper and on the rear of the load. The rear sign for mobile homes and factory-built structures must be mounted at least 7' above the highway surface, measuring from the bottom of the sign.

Lights - A flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning must be mounted on the towing unit and be visible from front and rear. More than one light may be necessary.

The permit-issuing authority may require additional escorts when deemed necessary. The signs or warning devices must be removed or covered when the vehicle is within legal dimensions.

This rule is intended to implement Iowa Code sections 321E.14, 321E.24 and 321E.34.
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.18(321,321E) Permit violations. Permit violations are to be reported to the permit-issuing authority by the arresting officer and the permit holder. If a permit holder is found to have willfully violated permit provisions, the vehicle and motor carrier services bureau may, after notice and hearing, suspend, modify or revoke the permit privileges of the permit holder consistent with Iowa Code section 321E.20.

This rule is intended to implement Iowa Code sections 321.492, 321E.16 and 321E.20.
[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

761—511.19(321) Movement of combination vehicles on economic export corridors.

511.19(1) Designation of economic export corridors.

a. The department may in its discretion establish economic export corridors for the transportation of goods or products manufactured in Iowa to or through the state of South Dakota and for the return of unladen semitrailers or unladen full trailers used for the transportation of those goods or products. An economic export corridor shall not include any segment of the interstate system or any part of the national network of highways identified pursuant to 23 CFR Part 658. However, if appropriate, the department may petition the Federal Highway Administration to remove a road or road segment from the national network of highways for the purpose of including it in an economic export corridor.

b. The department may initiate designation of economic export corridors, or a request for economic export corridor designation may be submitted to the department by an interested party. If a proposed economic export corridor includes any roads or road segments that are under the jurisdiction of a city or a county, a resolution from all relevant local jurisdictions must be submitted to the department indicating their support for economic export corridor designation. The resolution must include a description of the proposed economic export corridor under local jurisdiction.

c. The department shall exercise due regard for the safety of the traveling public and the protection of the highway surfaces and structures when establishing an economic export corridor. Factors to be considered include ability of the proposed economic export corridor to safely accommodate combinations of vehicles described in subrule 511.19(2), taking into account physical configurations and restrictions and traffic demands and capacity, as well as connection to markets that will benefit from the established economic export corridor.

d. The department will post established economic export corridors on the department's website.

511.19(2) Combination vehicles that may be operated on an economic export corridor.

a. In addition to combinations of vehicles lawful for operation on roads or road segments not designated as an economic export corridor, the following combinations of vehicles may be operated on

an economic export corridor designated under subrule 511.19(1) if the combinations of vehicles meet the requirements in paragraph 511.19(2) “b”:

(1) A truck tractor-semitrailer-semitrailer converted to a full trailer by use of a dolly equipped with a fifth wheel which is considered a part of the trailer for all purposes, and not a separate unit; or

(2) A truck tractor-semitrailer-full trailer; or

(3) A truck tractor-semitrailer-semitrailer combination, where the semitrailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

b. The combination of vehicles shall meet all of the following requirements:

(1) The length of the combination of vehicles, excluding the length of the truck tractor, shall not exceed 81½ feet.

(2) The length of either semitrailer or full trailer shall not exceed 45 feet.

(3) The weight of the second semitrailer or full trailer shall not exceed the weight of the first semitrailer by more than 3,000 pounds.

(4) The gross weight of the combination of vehicles shall not exceed 80,000 pounds and the combination of vehicles shall not exceed the gross axle weight limits of Iowa Code section 321.463(2).

(5) The load on each semitrailer or full trailer in the combination shall be an indivisible load. For the purpose of issuing permits for height or width under Iowa Code chapter 321E, the combination of vehicles shall be considered an indivisible load so long as the load on each semitrailer or full trailer in the combination remains an indivisible load.

c. The length of the frame extension shall not be included when determining the overall length of the first semitrailer in a truck tractor-semitrailer-semitrailer combination in which the semitrailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

d. For purposes of this subrule, “full trailer” means as defined in 49 CFR Section 390.5.

This rule is intended to implement Iowa Code section 321.457(2) “n.”

[ARC 3193C, IAB 7/5/17, effective 8/9/17; ARC 4985C, IAB 3/11/20, effective 4/15/20]

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[Filed ARC 4345C (Notice ARC 4231C, IAB 1/16/19), IAB 3/13/19, effective 4/17/19]

[Filed ARC 4985C (Notice ARC 4869C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

¹ Effective date of 511.2(1), 511.4(1)“a,” 511.4(2)“a” and “b,” 511.5(1), 511.5(6)“b”(3), 511.7, 511.8, 511.9(1) to 511.9(5), 511.14(2)“g” and “i,” 511.14(3)“e,” delayed 70 days by the Administrative Rules Review Committee at its meeting held May 12, 1993; delay lifted by this Committee June 8, 1993, effective June 9, 1993.

CHAPTER 607
COMMERCIAL DRIVER LICENSING

761—607.1(321) Scope. This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

761—607.2(17A) Information.

607.2(1) Information and location. Applications, forms and information about the commercial driver's license (CDL) are available at any driver's license service center. Assistance is also available by mail from the Driver and Identification Services Bureau, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department's website at www.iowadot.gov.

607.2(2) Manual. A copy of a study manual for the commercial driver's license tests is available upon request at any driver's license service center and on the department's website.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.3(321) Definitions. The definitions in Iowa Code section 321.1 apply to this chapter of rules. In addition, the following definitions are adopted:

"Air brake system" means a system that uses air as a medium for transmitting pressure or force from the driver's control to the service brake. "Air brake system" shall include any braking system operating fully or partially on the air brake principle.

"Air over hydraulic brakes" means any braking system operating partially on the air brake and partially on the hydraulic brake principle.

"Automatic transmission" means any transmission other than a manual transmission.

"CDLIS" means "commercial driver's license information system" as defined in Iowa Code section 321.1.

"Commercial driver's license downgrade" or *"CDL downgrade"* means either:

1. The driver changes the driver's self-certification of type of driving from non-excepted interstate to excepted interstate, non-excepted intrastate, or excepted intrastate driving, or
2. The department removed the CDL privilege from the driver's license.

"Commercial motor vehicle" or *"CMV"* as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. "Commercial motor vehicle" also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

"Controlled substance" as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

"Hazardous materials" means any material that has been designated as hazardous under 49 U.S.C. Section 5103 and is required to be placarded under 49 CFR Part 172, Subpart F, or any quantity of a material listed as a select agent or toxin in 42 CFR Part 73.

"Manual transmission" means a transmission utilizing a driver-operated clutch that is activated by a pedal or lever and a gear-shift mechanism operated either by hand or by foot. All other transmissions, whether semi-automatic or automatic, will be considered automatic.

"Medical examiner" means a person who is licensed, certified or registered, in accordance with applicable state laws and regulations, to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced registered nurse practitioners, and doctors of chiropractic.

"Medical examiner's certificate" means a certificate completed and signed by a medical examiner under the provisions of 49 CFR Section 391.43.

“*Medical variance*” means a driver has received one of the following from the Federal Motor Carrier Safety Administration that allows the driver to be issued a medical certificate:

1. An exemption letter permitting operation of a commercial motor vehicle pursuant to 49 CFR Part 381, Subpart C, or 49 CFR Section 391.62, or 49 CFR Section 391.64.
2. A skill performance evaluation certificate permitting operation of a commercial motor vehicle pursuant to 49 CFR Section 391.49.

“*Passenger vehicle*” means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.
2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

“*School bus*” means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events unless otherwise provided in Iowa Code section 321.1(69). “School bus” does not include a bus used as a common carrier.

“*Self-certification*” means a written certification of which category of type of driving an applicant for a commercial driver’s license engages in or intends to engage in, from the following categories:

1. Non-excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR Part 391, and is required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
2. Excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR Section 390.3(f), 391.2, 391.68 or 398.3 from all or parts of the qualification requirements of 49 CFR Part 391, and is therefore not required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
3. Non-excepted intrastate. The person certifies that the person operates only in intrastate commerce and is subject to state driver qualification requirements.
4. Excepted intrastate. The person certifies that the person operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements as set forth in Iowa Code section 321.449.

“*State,*” as used in this chapter and in “another state” in Iowa Code subsection 321.174(2), “former state of residence” in Iowa Code subsection 321.188(5), or “any state” in Iowa Code subsection 321.208(1), means one of the United States or the District of Columbia unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.188, 321.191, 321.193, 321.207 and 321.208.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.4 and **607.5** Reserved.

761—607.6(321) Exemptions.

607.6(1) *Persons exempt.* A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

607.6(2) *Exempt until April 1, 1992.* Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

761—607.7(321) Records. The operating record of a person who has been issued a commercial driver’s license or a commercial learner’s permit or a person who has been disqualified from operating

a commercial motor vehicle shall be maintained as provided in the department's "Record Management Manual" adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 and 321.199.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.8 and 607.9 Reserved.

761—607.10(321) Adoption of federal regulations.

607.10(1) Code of Federal Regulations. The department's administration of commercial driver's licenses shall be in compliance with the state procedures set forth in 49 CFR Section 383.73, and this chapter shall be construed to that effect. The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

- a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.
- b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.
- c. 49 CFR Part 380, Subpart F.
- d. The following portions of 49 CFR Part 383 (October 1, 2018):
 - (1) Section 383.51, Disqualification of drivers.
 - (2) Subpart E—Testing and Licensing Procedures.
 - (3) Subpart G—Required Knowledge and Skills.
 - (4) Subpart H—Tests.

607.10(2) Copies of regulations. Copies of the federal regulations may be reviewed at the state law library or through the Internet at www.fmcsa.dot.gov.

This rule is intended to implement Iowa Code sections 321.187, 321.188, 321.207, 321.208 and 321.208A.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 2986C, IAB 3/15/17, effective 4/19/17; ARC 3840C, IAB 6/6/18, effective 7/11/18; ARC 4401C, IAB 4/10/19, effective 5/15/19; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.11 to 607.14 Reserved.

761—607.15(321) Application. An applicant for a commercial driver's license shall comply with the requirements of Iowa Code sections 321.180(2) "e," 321.182 and 321.188, and 761—Chapter 601, and must provide the proofs of citizenship or lawful permanent residence and state of domicile required by 49 CFR Section 383.71. If the applicant is domiciled in a foreign jurisdiction and applying for a nondomiciled commercial driver's license, the applicant must provide a document required by 49 CFR Section 383.71(f).

This rule is intended to implement Iowa Code sections 321.180, 321.182 and 321.188.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.16(321) Commercial driver's license (CDL).

607.16(1) Classes. The department may issue a commercial driver's license only as a Class A, B or C driver's license. The license class identifies the types of vehicles that may be operated. A commercial driver's license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

607.16(2) Validity.

a. A Class A commercial driver's license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code section 321.189(1) "a." With the required endorsements and subject to the applicable restrictions, a Class A commercial driver's license is valid to operate any vehicle. Before the department administers the skills test for a Class A commercial driver's license to an applicant for the first time, the applicant must comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

b. A Class B commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code section 321.189(1) "b." With the required endorsements and subject to the

applicable restrictions, a Class B commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A commercial driver's license. Before the department administers the skills test for a Class B commercial driver's license to an applicant for the first time, the applicant must comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

c. A Class C commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1) "c." With the required endorsements and subject to the applicable restrictions, a Class C commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver's license.

d. A commercial driver's license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver's license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

e. A commercial driver's license valid for eight years shall be issued to a qualified applicant who is at least 18 years of age but not yet 72 years of age. However, the expiration date of the license issued shall not exceed the licensee's 74th birthday.

f. A commercial driver's license valid for two years shall be issued to a qualified applicant 72 years of age or older. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

g. A commercial driver's license is valid for 60 days after the expiration date.

h. A person with a commercial driver's license valid for the vehicle operated is not required to obtain a Class D driver's license to operate the vehicle as a chauffeur.

607.16(3) Requirements.

a. The minimum age to obtain a commercial driver's license is set out in 49 CFR, Part 391, Subpart B, except that, for a person operating solely intrastate, the driver age qualifications are set out in Iowa Code section 321.449(3).

b. The applicant shall meet the requirements set forth in rule 761—607.15(321).

607.16(4) Transition from five-year to eight-year licenses. During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department's computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, 321.196, and 321.449 and 2013 Iowa Acts, chapter 104, section 2.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.17(321) Endorsements. All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver's license are:

607.17(1) Hazardous material. A hazardous material endorsement (H) is required to transport hazardous materials. The hazardous material endorsement is only valid when the applicant or holder of the endorsement complies with the Transportation Security Administration's security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141. Before the department administers the knowledge test for a hazardous material endorsement to an applicant for the first time, the applicant shall comply with the entry-level driver training requirements as provided in Iowa Code section 321.188. To obtain or retain the hazardous material endorsement, the applicant or holder must pass a knowledge test as required under 49 CFR Section 383.121 and pay the endorsement fee. Retesting and

fee payment are also required when an applicant transfers a commercial driver's license from another state unless, as provided in 49 CFR Section 383.73, the transfer applicant provides evidence of passing the knowledge test as required under 49 CFR Section 383.121 within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer's farm to transport supplies to or from the farm.

607.17(2) Passenger vehicle. A passenger vehicle endorsement (P) is required to operate a passenger vehicle as defined in rule 761—607.3(321). Before the department administers the skills test for a passenger vehicle endorsement to an applicant for the first time, the applicant shall comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

607.17(3) Tank vehicle. A tank vehicle endorsement (N) is required to operate a tank vehicle as defined in Iowa Code section 321.1. A vehicle transporting a tank, regardless of the tank's capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

607.17(4) Double/triple trailer. A double/triple trailer endorsement (T) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

607.17(5) Hazardous material and tank. A combined endorsement (X) authorizes both hazardous material and tank vehicle operations.

607.17(6) School bus. A school bus endorsement (S) is required to operate a school bus as defined in rule 761—607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement. Before the department administers the skills test for a school bus endorsement to an applicant for the first time, the applicant shall comply with the entry-level driver training requirements as provided in Iowa Code section 321.188.

607.17(7) Exceptions for towing operations.

a. A driver who tows a vehicle in an emergency “first move” from the site of a vehicle malfunction or accident on a highway to the nearest appropriate repair facility is not required to have the endorsement(s) applicable to the towed vehicle. In any subsequent move, a driver who tows a vehicle from one repair or disposal facility to another is required to have the endorsement(s) applicable to the towed vehicle with one exception: A tow truck driver is not required to have a passenger endorsement to tow a passenger vehicle.

b. The double/triple trailer endorsement is not required to operate a commercial motor vehicle with two or more towed vehicles that are not trailers.

This rule is intended to implement Iowa Code sections 321.1, 321.176A, 321.188 and 321.189.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.18(321) Restrictions. The restrictions that may limit commercial motor vehicle operation with a commercial driver's license are listed in 761—subrule 605.8(3) and are explained below:

607.18(1) Air brake. The air brake restriction (L, no air brake equipped CMV) applies to a licensee who either fails the air brake component of the knowledge test or performs the skills test in a vehicle not equipped with air brakes and prohibits the operation of a commercial motor vehicle equipped with an air brake system until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(2) Full air brake. The full air brake restriction (Z, no full air brake equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with air over hydraulic brakes and prohibits the operation of a commercial motor vehicle equipped with any braking system operating fully on the air brake principle until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(3) Manual transmission. The manual transmission restriction (E, no manual transmission equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with automatic

transmission and prohibits the operation of a commercial motor vehicle equipped with a manual transmission until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(4) *Tractor-trailer.* The tractor-trailer restriction (O, no tractor trailer CMV) applies to a licensee who performs the skills test in a combination vehicle for a Class A commercial driver's license with the power unit and towed unit connected with a pintle hook or other non-fifth wheel connection and prohibits operation of a tractor-trailer combination connected by a fifth wheel that requires a Class A commercial driver's license until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

607.18(5) *Class A passenger vehicle.* The Class A passenger vehicle restriction (M, no Class A passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class B commercial driver's license and prohibits operation of a passenger vehicle that requires a Class A commercial driver's license.

607.18(6) *Class A and B passenger vehicle.* The Class A and B passenger vehicle restriction (N, no Class A and B passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class C commercial driver's license and prohibits operation of a passenger vehicle that requires a Class A or Class B commercial driver's license.

607.18(7) *Intrastate only.* The intrastate only restriction (K, intrastate only) applies to a licensee who self-certifies to non-excepted intrastate or excepted intrastate driving and prohibits the operation of a commercial motor vehicle in interstate commerce.

607.18(8) *Medical variance.* The medical variance restriction (V, medical variance) applies to a licensee when the department is notified pursuant to 49 CFR Section 383.73(o)(3) that the driver has been issued a medical variance and indicates there is information about a medical variance on the CDLIS driver record.

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4586C, IAB 7/31/19, effective 9/4/19]

761—607.19 Reserved.

761—607.20(321) Commercial learner's permit.

607.20(1) *Validity.*

a. A commercial learner's permit allows the permit holder to operate a commercial motor vehicle when accompanied as required by Iowa Code section 321.180(2) "d."

b. A commercial learner's permit is valid for one year without retaking the general and endorsement knowledge tests required by Iowa Code section 321.188.

c. A commercial learner's permit is invalid after the expiration date of the underlying commercial or noncommercial driver's license issued to the permit holder or the expiration date of the permit whichever occurs first.

d. The issuance of a commercial learner's permit is a precondition to the initial issuance of a commercial driver's license. The issuance of a commercial learner's permit is also a precondition to the upgrade of a commercial driver's license if the upgrade requires a skills test. If the permit holder is subject to the requirement to complete entry-level driver training as provided in Iowa Code section 321.188, the permit holder shall complete the training after the permit holder obtains the commercial learner's permit, but before the permit holder takes the required skills test. The holder of a commercial learner's permit is not eligible to take a required driving skills test for the first 14 days after the permit holder is issued the permit. The 14-day period includes the day the commercial learner's permit was issued.

EXAMPLE: The commercial learner's permit is issued on September 1. The earliest date the permit holder would be eligible to take the skills test is September 15.

e. A commercial learner's permit is not valid for the operation of a vehicle transporting hazardous materials.

607.20(2) *Requirements.*

a. An applicant for a commercial learner's permit must hold a valid Class A, B, C, or D driver's license issued in this state that is not an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license; must be at least 18 years of age; and must meet the requirements to obtain a valid commercial driver's license, including the requirements set forth in Iowa Code section 321.188. However, the applicant does not have to complete the driving skills tests required for a commercial driver's license to obtain a commercial learner's permit.

b. The applicant must successfully pass a general knowledge test that meets the federal standards contained in 49 CFR Part 383, Subparts F, G and H, for the commercial motor vehicle the applicant operates or expects to operate, including any endorsement for which the applicant applies.

607.20(3) Endorsements. A commercial learner's permit may include the following endorsements. All other endorsements are prohibited on a commercial learner's permit.

a. An applicant for a passenger endorsement (P) must take and pass the passenger endorsement knowledge test. A commercial learner's permit holder with a passenger endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

b. An applicant for a school bus endorsement (S) must take and pass the school bus endorsement knowledge test. A commercial learner's permit holder with a school bus endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

c. An applicant for a tank vehicle endorsement (N) must take and pass the tank vehicle endorsement knowledge test. A commercial learner's permit holder with a tank vehicle endorsement may only operate an empty tank vehicle and is prohibited from operating any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

607.20(4) Restrictions. A commercial learner's permit may include the air brake (L), medical variance (V), Class A passenger vehicle (M), Class A and B passenger vehicle (N) and intrastate only (K) restrictions described in rule 761—607.18(321). In addition, a commercial learner's permit may include the following restrictions that are specific to the commercial learner's permit:

a. Passenger. The passenger restriction (P, no passengers in CMV bus) applies to a permit holder who has a commercial learner's permit with a passenger or school bus endorsement and prohibits the operation of a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

b. Cargo. The cargo restriction (X, no cargo in CMV tank vehicle) applies to a permit holder who has a commercial learner's permit with a tank vehicle endorsement and prohibits the operation of any tank vehicle containing cargo or any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

This rule is intended to implement Iowa Code sections 321.180, 321.186 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.21 to 607.24 Reserved.

761—607.25(321) Examination for a commercial driver's license. In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver's license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

761—607.26(321) Vision screening. An applicant for a commercial driver's license or commercial learner's permit must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

761—607.27(321) Knowledge tests.

607.27(1) General knowledge test. The general knowledge test for a commercial driver's license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

607.27(2) Additional tests. In addition to the general knowledge test for a commercial driver's license, an additional knowledge test is required for each of the following:

- a. Class A license for combination vehicle operation as required in 49 CFR Section 383.111.
- b. Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.
- c. Passenger vehicle endorsement as required in 49 CFR Section 383.117.
- d. Tank vehicle endorsement as required in 49 CFR Section 383.119.
- e. Double/triple trailer endorsement as required in 49 CFR Section 383.115.
- f. School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.
- g. Removal of the air brake restriction as required in 49 CFR Section 383.111.

607.27(3) Test methods. All knowledge tests shall be administered in compliance with 49 CFR Section 383.133(b). All tests other than the hazardous material endorsement test may be administered in written form, verbally, or in automated format and can be administered in a foreign language, provided no interpreter is used in administering the test. A verbal test shall be offered only at specified locations. Information about the locations is available at any driver's license service center.

607.27(4) Waiver. A waiver of any knowledge test is permitted only as provided in Iowa Code section 321.188(5) and this chapter. The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.

607.27(5) Military waiver. The department may waive the requirement that an applicant pass a required knowledge test for an applicant who is a current or former military service member as defined in 49 CFR Section 383.5. An applicant for a waiver of the knowledge test under this subrule shall certify and provide evidence, as required by the department, that the following apply:

- a. The applicant is regularly employed or was regularly employed within the past year in a military position specifically designated in 49 CFR Section 383.77.
- b. The applicant is or was operating a vehicle representative of the commercial motor vehicle the applicant operates or expects to operate immediately preceding honorable separation from military service as evidenced by the applicant's certificate of release or discharge from active duty, commonly referred to as a DD form 214.
- c. The applicant has not had more than one driver's license, other than a military license.
- d. The applicant has not had any driver's license suspended, revoked, or canceled.
- e. The applicant has not been convicted of an offense committed while operating any type of motor vehicle that is listed as a disqualifying offense in 49 CFR Section 383.51(b).
- f. The applicant has not had more than one conviction for an offense committed while operating any type of motor vehicle that is listed as a serious traffic violation in 49 CFR Section 383.51(c).
- g. The applicant has not had a conviction for violation of a military, state, or local law relating to motor vehicle traffic control, other than a parking violation, arising in connection with any traffic accident, and has no record of an accident in which the applicant was at fault.

607.27(6) Requirement. An applicant must pass the applicable knowledge test(s) before taking the skills test. Passing scores for a knowledge test shall meet the standards contained in 49 CFR Section 383.135(a).

This rule is intended to implement Iowa Code sections 321.186 and 321.188.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.28(321) Skills test.

607.28(1) Content. The skills test for a commercial driver's license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H.

607.28(2) Test methods. All skills tests shall be administered in compliance with 49 CFR Section 383.133(c). Interpreters are prohibited during the administration of skills tests. Applicants must be able to understand and respond to verbal commands and instructions in English by a skills test examiner. Neither the applicant nor the examiner may communicate in a language other than English during the skills test.

607.28(3) Order. The skills test must be administered and successfully completed in the following order: pre-trip inspection, basic vehicle control skills, on-road skills. If an applicant fails one segment of the skills test, the applicant cannot continue to the next segment of the test, and scores for the passed segments of the test are only valid during initial issuance of the commercial learner's permit.

607.28(4) Vehicle. The applicant shall provide a representative vehicle for the skills test. "Representative vehicle" means a commercial motor vehicle that meets the statutory description for the class of license applied for.

a. To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 761—607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

b. To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 761—607.3(321), in the same vehicle class as the applicant will drive, as required in 49 CFR Section 383.123.

c. To obtain a tank endorsement, the applicant must take the skills test in a representative vehicle for the class of license applied for, but the representative vehicle is not required to be a tank vehicle.

d. To remove an air brake or full air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 761—607.3(321) and as required in 49 CFR Section 383.113.

e. To remove a manual transmission restriction, the applicant must take the on-road segment of the skills test in a vehicle equipped with a manual transmission, as defined in rule 761—607.3(321).

607.28(5) Skills test scoring. Passing scores for a skills test shall meet the standards contained in 49 CFR Section 383.135(b).

607.28(6) Military waiver. The department may waive the requirement that an applicant pass a required skills test for an applicant who is on active duty in the military service or who has separated from such service in the past year, provided the applicant meets the requirements of Iowa Code subsection 321.188(6).

607.28(7) Locations. The skills test for a commercial driver's license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver's license service center for the location of the nearest skills testing center. A skills test by appointment shall be offered only at specified regional test sites.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.29(321) Waiver of skills test. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.30(321) Third-party testing.

607.30(1) Purpose and definitions. The skills test required by rule 761—607.28(321) may be administered by third-party testers and third-party skills test examiners approved and certified by the department. For the purpose of administering third-party skills testing and this rule, the following definitions shall apply:

“*Community college*” means an Iowa community college established under Iowa Code chapter 260C.

“*Iowa-based motor carrier*” means a motor carrier or its subsidiary that has its principal place of business in the state of Iowa and operates a permanent commercial driver training facility in the state of Iowa.

“*Iowa nonprofit corporation*” means a nonprofit corporation that serves as a trade association for Iowa-based motor carriers.

“*Motor carrier*” means the same as defined in 49 CFR Section 390.5.

“*Permanent commercial driver training facility*” means a facility dedicated to a program of commercial driving instruction that is offered to employees or potential employees of the motor carrier as incident to the motor carrier’s commercial operations, that requires at least 40 hours of instruction, and that includes fixed and permanent structures and facilities for the off-road portions of commercial driving instruction, including classroom, pretrip inspection, and basic vehicle control skills. A permanent commercial driver training facility must include a fixed and paved or otherwise hard-surfaced area for basic vehicle control skills testing that is permanently marked and capable of inspection and measurement by the department.

“*Skills test*” means the skills test required by rule 761—607.28(321).

“*Subsidiary*” means a company that is partly or wholly owned by a motor carrier that holds a controlling interest in the subsidiary company.

“*Third-party skills test examiner*” means the same as defined in 49 CFR Section 383.5.

“*Third-party tester*” means the same as defined in 49 CFR Section 383.5.

607.30(2) Certification of third-party testers.

a. The department may certify as a third-party tester a community college, Iowa-based motor carrier or Iowa nonprofit corporation to administer skills tests. A community college, Iowa-based motor carrier or Iowa nonprofit corporation that seeks certification as a third-party tester shall contact the driver and identification services bureau and schedule a review of the proposed testing program, which shall include the proposed testing courses and facilities, information sufficient to identify all proposed third-party skills test examiners, and any other information necessary to demonstrate compliance with 49 CFR Section 383.75.

b. No community college, Iowa-based motor carrier or Iowa nonprofit corporation shall be certified to conduct third-party testing unless and until the community college, Iowa-based motor carrier or Iowa nonprofit corporation enters an agreement with the department that meets the requirements of 49 CFR Section 383.75 and demonstrates sufficient ability to conduct skills tests in a manner that consistently meets the requirements of 49 CFR Section 383.75.

c. The department shall issue a certified third-party tester a certificate of authority that identifies the classes and types of vehicles for which skills tests may be administered. The certificate shall be valid for the duration of the agreement executed pursuant to paragraph 607.30(2)“b,” unless revoked by the department for engaging in fraudulent activities related to conducting skills tests or failing to comply with the requirements, qualifications, and standards of this chapter, the agreement, or 49 CFR Section 383.75.

607.30(3) Certification of third-party skills test examiners.

a. A certified third-party tester shall not employ or otherwise use as a third-party skills test examiner a person who has not been approved and certified by the department to administer skills tests. Each certified third-party tester shall submit for approval the names of all proposed third-party skills test examiners to the department. The department shall not approve as a third-party skills test examiner a person who does not meet the requirements, qualifications and standards of 49 CFR Sections 383.75 and 384.228, including but not limited to all required training and examination and a nationwide criminal

background check. The criteria for passing the nationwide criminal background check shall include no felony convictions within the last ten years and no convictions involving fraudulent activities.

b. The department shall issue a certificate of authority for each person certified as a third-party skills test examiner that identifies the certified third-party tester for which the person will administer skills tests and the classes and types of vehicles for which the person may administer skills tests. The certificate shall be valid for a period of four years from the date of issuance of the certificate.

c. The department shall revoke the certificate if the person holding the certificate does not administer skills tests to at least ten different applicants per calendar year; does not successfully complete the refresher training required by 49 CFR Section 384.228 every four years; is involved in fraudulent activities related to conducting skills tests; or otherwise fails to comply with and meet the requirements, qualifications and standards of this chapter or 49 CFR Sections 383.75 and 384.228. Notwithstanding anything in this paragraph to the contrary, as provided in 49 CFR Section 383.75, if the person does not administer skills tests to at least ten different applicants per calendar year, the certificate will not be revoked for that reason if the person provides proof of completion of the examiner refresher training in 49 CFR Section 384.228 to the department or successfully completes one skills test under the observation of a department examiner.

d. A third-party skills test examiner who is also a skills instructor shall not administer a skills test to an applicant who received skills training from that third-party skills test examiner.

e. A third-party skills test examiner may only administer CDL skills tests for the examiner's primary employer, unless authorized by the department to administer CDL skills tests for another county or third-party tester.

607.30(4) Bond. As a condition of certification, an Iowa-based motor carrier or Iowa nonprofit corporation must maintain a bond in the amount of \$50,000 to pay for the retesting of drivers in the event that the third-party tester or one or more of its third-party skills test examiners are involved in fraudulent activities related to conducting skills tests of applicants for a commercial driver's license.

607.30(5) Limitation applicable to Iowa-based motor carriers. An Iowa-based motor carrier certified as a third-party tester may only administer the skills test to persons who are enrolled in the Iowa-based motor carrier's commercial driving instruction program and shall not administer skills tests to persons who are not enrolled in that program.

607.30(6) Training and refresher training for third-party skills test examiners. All training and refresher training required under this rule shall be provided by the department, in form and content that meet the recommendations of the American Association of Motor Vehicle Administrators' International Third-Party Examiner/Tester Certification Program.

This rule is intended to implement Iowa Code section 321.187.
[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.31(321) Test results.

607.31(1) Period of validity. Passing knowledge and skills test results shall remain valid for a period of one year.

607.31(2) Retesting. Subject to rule 761—607.28(321), an applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day. An applicant may be required to repeat a test if the department determines the test was improperly administered.

607.31(3) Skills test results from other states. As required by 49 CFR Section 383.79, the department shall accept the valid results of a skills test administered to an applicant who is domiciled in the state of Iowa and that was administered by another state, in accordance with 49 CFR Part 383, Subparts F, G and H, in fulfillment of the applicant's testing requirements under 49 CFR Section 383.71 and the state's test administration requirements under 49 CFR Section 383.73. The results must be transmitted directly from the testing state to the department as required by 49 CFR Section 383.79.

607.31(4) Skills test results from certified third-party testers. A third-party skills tester certified under rule 761—607.30(321) shall transmit the skills test results of tests administered by the third-party tester through secure electronic means determined by the department. The department may retest any

person who has passed a skills test administered by a certified third-party tester if it appears to the department that the skills test administered by the third-party tester was administered fraudulently or improperly, and as needed to meet the third-party skills test examiner oversight requirements of 49 CFR Section 383.75(a)(5).

This rule is intended to implement Iowa Code sections 321.180, 321.186, 321.187 and 321.188. [ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.32(321) Knowledge and skills testing of nondomiciled military personnel.

607.32(1) *Role of state of duty station.* The department may accept an application for a CLP or CDL, including an application for waiver of the knowledge test as provided in subrule 607.27(5), if the applicant is an active duty military service member stationed, but not domiciled, in Iowa, and the department has an agreement to accept such applications with the applicant's state of domicile as provided in 49 CFR Section 383.79.

a. The applicant shall certify and provide evidence that the following apply:

(1) The applicant is regularly employed or was regularly employed within the past year in a military position requiring operation of a commercial motor vehicle.

(2) The applicant has a valid driver's license from the applicant's state of domicile.

(3) The applicant has a valid active duty military identification card.

(4) The applicant has a current copy of either the applicant's military leave and earnings statement or the applicant's orders.

b. If the applicant meets the requirements of paragraph 607.32(1) "a" and the department has an agreement with the applicant's state of domicile as provided in this subrule, the department may do either of the following:

(1) Administer the knowledge and skills tests to the applicant as appropriate in accordance with 49 CFR Part 383, Subparts F, G, and H, if the state of domicile requires those tests; or

(2) Waive the knowledge and skills tests in accordance with 49 CFR Section 383.77 and this chapter if the state of domicile also permits waiver of the knowledge and skills test.

c. The department may destroy the applicant's driver's license on behalf of the state of domicile unless the state of domicile requires the driver's license to be surrendered to the state of domicile's driver's licensing agency.

607.32(2) *Electronic transmission of application and test results.* The department shall transmit to the state of domicile the applicant's application, any supporting documents and the results of any skills or knowledge tests administered as provided under this rule.

607.32(3) *Role of state of domicile.* If the department has an agreement with the applicant's state of duty station, upon completion of the applicant's application pursuant to 49 CFR Section 383.71 and any testing administered by the applicant's state of duty station pursuant to 49 CFR Sections 383.71 and 383.73, the department may do all of the following:

a. Accept the completed application, any supporting documents, and the results of the knowledge and skills tests administered by the applicant's state of duty station.

b. Issue the applicant a CLP or CDL.

This rule is intended to implement Iowa Code sections 321.180, 321.186, 321.187, and 321.188 and 49 CFR Part 383.

[ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.33 and 607.34 Reserved.

761—607.35(321) Issuance of commercial driver's license and commercial learner's permit. A commercial driver's license or commercial learner's permit issued by the department shall include the information and markings required by Iowa Code section 321.189(2) "b."

This rule is intended to implement Iowa Code section 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

761—607.36(321) Conversion to commercial driver's license. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.37(321) Commercial driver's license renewal. The department shall administer commercial driver's license renewals as required by 49 CFR Section 383.73.

607.37(1) Licensee requirements. To renew a commercial driver's license, the licensee shall apply at a driver's license service center and complete the following requirements:

a. The licensee shall make a written self-certification of type of driving as required by rule 761—607.50(321) and provide a current medical examiner's certificate if required.

b. If the licensee has and wishes to retain a hazardous material endorsement, the licensee shall pass the test required in 49 CFR Section 383.121 and comply with the Transportation Security Administration security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141 for such endorsement. A lawful permanent resident of the United States must also provide the licensee's U.S. Citizenship and Immigration Services alien registration number.

c. The licensee shall provide proof of citizenship or lawful permanent residency and state of domicile as required by rule 761—607.15(321) and 49 CFR 383.73(d)(7). Proof of citizenship or lawful permanent residency is not required if the licensee provided such proof at initial issuance or a previous renewal or upgrade of the license and the department has a notation on the licensee's record confirming that the required proof of legal citizenship or legal presence check was made and the date on which it was made.

d. If the licensee is domiciled in a foreign jurisdiction and renewing a non-domiciled commercial driver's license, the licensee must provide a document required by 49 CFR 383.71(f) at each renewal.

607.37(2) Early renewal. A valid commercial driver's license may be renewed 90 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed 364 days prior to the expiration date. The department may allow renewal earlier than 364 days prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

This rule is intended to implement Iowa Code sections 321.186, 321.188 and 321.196.

[ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.38(321) Transfers from another state. Upon initial application for an Iowa license, an Iowa resident who has a valid commercial driver's license from a former state of residence is not required to retest except as specified in Iowa Code subsection 321.188(5) but is required to pay the applicable endorsement and restriction removal fees.

This rule is intended to implement Iowa Code sections 321.188 and 321.191.

761—607.39(321) Disqualification.

607.39(1) Date. A disqualifying act, action or offense under Iowa Code section 321.208, that occurred before July 1, 1990, shall not be grounds for disqualification from operating a commercial motor vehicle.

607.39(2) Notice. A 30-day advance notice of disqualification shall be served by the department in accordance with rule 761—615.37(321). Pursuant to Iowa Code subsection 321.208(12), a peace officer on behalf of the department may serve the notice of disqualification immediately.

607.39(3) Hearing and appeal process. A person who has received a notice of disqualification may contest the disqualification in accordance with 761—615.38(17A,321).

607.39(4) Reduction of lifetime disqualification.

a. As permitted by 49 CFR Section 383.51, a person subject to lifetime disqualification of the person's commercial driving privileges may apply to the department for reinstatement. The approval is subject to the discretion of the department and subject to the following requirements:

(1) The request may not be made prior to ten years from the effective date of the lifetime disqualification.

(2) The person must submit the request in a manner prescribed by the department.

(3) If the driving record contains alcohol-related or drug-related offenses that resulted in the lifetime disqualification, the person must have completed an alcohol or drug evaluation and have completed any recommended treatment which meets or exceeds the minimum standards approved by the Iowa department of public health. Evidence of a completed evaluation and treatment must be on file with the department or submitted with the application for reinstatement.

(4) Within the ten years preceding the request, the person must not have any of the following moving violation convictions:

1. A drug or alcohol offense.
2. Leaving the scene of an accident.
3. A felony involving the use of any motor vehicle.
4. Any moving violation while operating a commercial motor vehicle.

(5) The department may request, and the person shall provide, any additional information or documentation necessary to determine the person's eligibility for reinstatement or general fitness for licensure.

b. If the department finds the person is eligible for reinstatement under this subrule, the person shall do all of the following prior to reinstatement:

- (1) Pay all outstanding reinstatement fees.
- (2) Meet all outstanding reinstatement requirements.
- (3) Pass the required knowledge, vision, and skills tests as specified in Iowa Code section 321.188.
- (4) Complete any other courses or requirements as required by the director.

c. As provided in 49 CFR Section 383.51(a)(6), a person who has previously had the person's commercial driving privileges reinstated pursuant to this subrule shall not be eligible to apply for reinstatement following conviction of a subsequent disqualifying offense.

d. If the department determines the person is not eligible for reinstatement as provided in this subrule, the department shall send notice by first-class mail to the person's mailing address as shown on departmental records that the lifetime disqualification remains in effect.

607.39(5) *Fraud related to testing and issuance.*

a. As required by 49 CFR Section 383.73(k) and Iowa Code section 321.201(2)“*b*,” the department shall disqualify the commercial driver's license or commercial learner's permit of a person convicted or suspected of fraud related to the testing for or issuance of a commercial driver's license or commercial learner's permit.

b. Upon receipt of a person's conviction of fraud related to the issuance of the commercial driver's license or commercial learner's permit, the department shall disqualify the person's commercial driver's license or commercial learner's permit for one year.

c. Upon receipt of credible evidence that a person is suspected of committing fraud relating to the issuance of a commercial driver's license or a commercial learner's permit, the department shall notify the person of the requirement to retake the applicable knowledge or skills test. Within 30 days of receiving notice from the department, the person is required to contact the department to retake the knowledge or skills test. If the person fails to contact the department within 30 days after the notice, or the person fails the knowledge or skills test, or does not take the test, the department shall disqualify the person's commercial driver's license or commercial learner's permit.

d. Once a person's commercial driver's license or commercial learner's permit has been disqualified, the person must reapply following the usual procedures as provided in Iowa Code section 321.188 and this chapter.

This rule is intended to implement Iowa Code chapter 17A and section 321.208.
[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.40(321) Sanctions. When a person's motor vehicle license is denied, canceled, suspended, revoked or barred, the person is also disqualified from operating a commercial motor vehicle.

This rule is intended to implement Iowa Code section 321.208.

761—607.41 to 607.44 Reserved.

761—607.45(321) Reinstatement. To reinstate a commercial driver's license after completion of a period of disqualification, a person shall appear at a driver's license service center. The person must also meet the vision standards for licensing, pass the applicable knowledge test(s) and the skills test, and pay the required reinstatement fee and the fees for a new license.

This rule is intended to implement Iowa Code sections 321.191 and 321.208.
[ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.46 to 607.48 Reserved.

761—607.49(321) Restricted commercial driver's license.

607.49(1) Scope. This rule pertains to the issuance of restricted commercial driver's licenses to suppliers or employees of suppliers of agricultural inputs. Issuance is permitted by 49 CFR 383.3(f). A restricted commercial driver's license shall meet all requirements of a regular commercial driver's license, as set out in Iowa Code chapter 321 and this chapter of rules, except as specified in this rule.

607.49(2) Agricultural inputs. The term "agricultural inputs" means suppliers or applicators of agricultural chemicals, fertilizer, seed or animal feeds.

607.49(3) Validity.

a. A restricted commercial driver's license allows the licensee to drive a commercial motor vehicle for agricultural input purposes. The license is valid to:

(1) Operate Group B and Group C commercial motor vehicles including tank vehicles and vehicles equipped with air brakes, except passenger vehicles.

(2) Transport the hazardous materials listed in paragraph 607.49(3) "b."

(3) Operate only during the current, validated seasonal period.

(4) Operate between the employer's place of business and the farm currently being served, not to exceed 150 miles.

b. A restricted commercial driver's license is not valid for transporting hazardous materials requiring placarding, except as follows:

(1) Liquid fertilizers such as anhydrous ammonia may be transported in vehicles or implements of husbandry with total capacities of 3,000 gallons or less.

(2) Solid fertilizers such as ammonium nitrate may be transported provided they are not mixed with any organic substance.

(3) A hazardous material endorsement is not needed to transport the products listed in the preceding subparagraphs.

c. When not driving for agricultural input purposes, the license is valid for operating a noncommercial motor vehicle that may be legally operated under the noncommercial license held by the licensee.

607.49(4) Requirements.

a. The applicant must have two years of previous driving experience. This means that the applicant must have held a license that permits unaccompanied driving for at least two years. This does not include a motorized bicycle license, a minor's school license or a minor's restricted license.

b. The applicant must have a good driving record for the most recent two-year period, as defined in subrule 607.49(5).

c. An applicant who currently holds an unrestricted commercial driver's license is not eligible for issuance of a restricted commercial driver's license.

607.49(5) Good driving record. A "good driving record" means a driving record showing:

a. No multiple licenses.

b. No driver's license suspensions, revocations, disqualifications, denials, bars, or cancellations of any kind.

c. No convictions in any type of motor vehicle for:

(1) Driving under the influence of alcohol or drugs.

(2) Leaving the scene of an accident.

(3) Committing any felony involving a motor vehicle.

- (4) Speeding 15 miles per hour or more over the posted speed limit.
 - (5) Reckless driving, drag racing, or eluding or attempting to elude a law enforcement officer.
 - (6) Improper or erratic lane changes.
 - (7) Following too closely.
 - (8) A moving violation that contributed to a motor vehicle accident.
 - (9) A violation deemed serious under rule 761—615.17(321).
- d.* No record of contributive accidents, as defined in rule 761—615.1(321).

607.49(6) Issuance.

a. The knowledge and skills tests described in rules 761—607.27(321) and 761—607.28(321) are waived.

b. A restricted commercial driver's license shall be coded with restriction "W" on the face of the driver's license, with the restriction explained in text on the back of the driver's license. In addition, the license shall be issued with a restriction stating the license's period of validity.

c. The expiration date for a restricted commercial driver's license that is converted to this license from another Iowa license shall carry the same expiration date as the previous license.

d. A restricted commercial driver's license may be renewed for the period of time specified in Iowa Code section 321.196. The licensee's good driving record shall be confirmed at the time of renewal.

e. The fee for a restricted commercial driver's license shall be as specified in Iowa Code section 321.191.

f. On or after January 1, 2017, a licensee may have up to three individual periods of validity for a restricted commercial driver's license, provided the cumulative period of validity for all individual periods does not exceed 180 days in any calendar year. An individual period of validity may be 60, 90, or 180 consecutive days, at the election of the licensee. A licensee may add 30 days to an individual period of validity by applying for an extension, subject to the 180-day cumulative maximum period of validity. A request for extension must be made no later than the date of expiration of the individual period of validity for which an extension is requested; a request for extension made after that date shall be treated as a request for a new individual period of validity. An extension shall be calculated from the date of expiration of the individual period of validity for which an extension is requested. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day cumulative maximum period of validity.

g. A restricted commercial driver's license must be validated for commercial motor vehicle operation for each individual period of validity. This means that the applicant/licensee must have the person's good driving record confirmed at each application for an individual period of validity. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that individual period of validity, provided the person is otherwise eligible for the license. The fee for a replacement license shall be as specified in Iowa Code section 321.195.

h. The same process must be repeated for each individual period of validity within a calendar year.

This rule is intended to implement Iowa Code section 321.176B.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.50(321) Self-certification of type of driving and submission of medical examiner's certificate.

607.50(1) *Applicants for commercial learner's permit, restricted CDL, or new, transferred, renewed or upgraded CDL.*

a. A person shall provide to the department a self-certification of type of driving if the person is applying for:

- (1) A commercial learner's permit,
- (2) An initial commercial driver's license,
- (3) A transfer of a commercial driver's license from a prior state of domicile to the state of Iowa,
- (4) Renewal of a commercial driver's license,

(5) A license upgrade for a commercial driver's license or an endorsement authorizing the operation of a commercial motor vehicle not covered by the current commercial driver's license, or

(6) A restricted commercial driver's license.

b. The self-certification shall be on a form or in a format, which may be electronic, as provided by the department.

607.50(2) *Submission of medical examiner's certificate by persons certifying to non-excepted interstate driving.* Every person who self-certifies to non-excepted interstate driving must give the department a copy of the person's current medical examiner's certificate. A person who fails to provide a required medical examiner's certificate shall not be allowed to proceed with an initial issuance, transfer, renewal, or upgrade of a license until the person gives the department a medical examiner's certificate that complies with the requirements of this subrule, or changes the person's self-certification of type of driving to a type other than non-excepted interstate driving. For persons submitting a current medical examiner's certificate, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record. A person who self-certifies to a type of driving other than non-excepted interstate shall have no medical certification status on the CDLIS driver's record.

607.50(3) *Maintaining certified status.* To maintain a medical certification status of "certified," a person who self-certifies to non-excepted interstate driving must give the department a copy of each subsequently issued medical examiner's certificate valid for the person. The copy must be given to the department at least ten days before the previous medical examiner's certificate expires.

607.50(4) *CDL downgrade.* If the medical examiner's certificate or medical variance for a person self-certifying to non-excepted interstate driving expires or if the Federal Motor Carrier Safety Administration notifies the department that the person's medical variance was removed or rescinded, the department shall post a medical certification status of "not certified" to the person's CDLIS driver's record and shall initiate a downgrade of the person's commercial driver's license or commercial learner's permit. The medical examiner's certificate of a person who fails to maintain a medical certification status of "certified" as required by subrule 607.50(3) shall be deemed to be expired on the date of expiration of the last medical examiner's certificate filed for the person as shown by the person's CDLIS driver's record. The downgrade will be initiated and completed as follows:

a. The department shall give the person written notice that the person's medical certification status is "not certified" and that the commercial motor vehicle privileges will be removed from the person's commercial driver's license or commercial learner's permit 60 days after the date the medical examiner's certificate or medical variance expired or the medical variance was removed or rescinded unless the person submits to the department a current medical certificate or medical variance or self-certifies to a type of driving other than non-excepted interstate.

b. If the person submits a current medical examiner's certificate or medical variance before the end of the 60-day period, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record and shall terminate the downgrade of the person's commercial driver's license or commercial learner's permit.

c. If the person self-certifies to a type of driving other than non-excepted interstate before the end of the 60-day period, the department shall not remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit, and the person will have no medical certification status on the person's CDLIS driver's record.

d. If the person fails to take the action in either paragraph 607.50(4) "b" or "c" before the end of the 60-day period, the department shall remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit and shall leave the person's medical certification status as "not certified" on the person's CDLIS driver's record.

607.50(5) *Establishment or reestablishment of "certified" status.* A person who has no medical certification status or whose medical certification status has been posted as "not certified" on the person's CDLIS driver's record may establish or reestablish the status as "certified" by submitting a current medical examiner's certificate or medical variance to the department. A person who has failed to self-certify to a type of driving or has self-certified to a type of driving other than non-excepted interstate must also make a self-certification of type of driving to non-excepted interstate driving. The

department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record.

607.50(6) Reestablishment of the CDL privilege. A person whose commercial motor vehicle privileges have been removed from the person’s commercial driver’s license or commercial learner’s permit under the provisions of paragraph 607.50(4) “d” may reestablish the commercial motor vehicle privileges by either of the following methods:

a. Submitting a current medical examiner’s certificate or medical variance to the department. A person who has failed to self-certify to a type of driving must also make an initial self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record and reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit.

b. Self-certifying to a type of driving other than non-excepted interstate. The department shall then reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit; the person will have no medical certification status on the driver’s CDLIS driver’s record.

607.50(7) Change of type of driving. A person may change the person’s self-certification of type of driving at any time. As required by subrule 607.50(2), a person certifying to non-excepted interstate driving must give the department a copy of the person’s current medical examiner’s certificate prepared by a medical examiner.

607.50(8) Record keeping. The department shall comply with the medical record-keeping requirements set forth in 49 CFR Section 383.73.

This rule is intended to implement Iowa Code sections 321.182, 321.188 and 321.207.

[ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 4986C, IAB 3/11/20, effective 4/15/20]

761—607.51(321) Determination of gross vehicle weight rating.

607.51(1) Actual weight prohibited. In determining whether the vehicle is a representative vehicle for the skills test and the group of commercial driver’s license for which the applicant is applying, the vehicle’s gross weight rating or gross combination weight rating must be used, not the vehicle’s actual gross weight or gross combination weight. For purposes of this rule, “gross weight rating” and “gross combination weight rating” mean as defined in 49 CFR Section 383.5.

607.51(2) Vehicle without legible manufacturer’s certification label. To complete a skills test using a vehicle that has no legible manufacturer’s certification label, whether a power unit or towed vehicle, the applicant must provide documentation of the vehicle’s gross vehicle weight rating, such as a manufacturer’s certificate of origin, a title, or the vehicle identification number information for the vehicle. In the absence of such documentation, the vehicle may not be used, either alone or in combination.

This rule is intended to implement Iowa Code section 321.1.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

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CHAPTER 11
INJURED VETERANS GRANT PROGRAM

2006-2007 PROGRAM GUIDELINES

801—11.1(35A) Purpose. The legislative intent of this program is to provide immediate financial assistance to a veteran so that family members of the veteran may be with the veteran during the veteran’s recovery from an injury received in the line of duty in a combat zone or in a zone where the veteran was receiving hazardous duty pay after September 11, 2001.

[ARC 0057C, IAB 4/4/12, effective 5/9/12]

801—11.2(35A) Grant amounts.

11.2(1) Grants will be paid by the Iowa department of veterans affairs in increments of \$2,500 up to a maximum of \$10,000 in the following manner:

- \$2,500 When veteran is medically evacuated from the combat zone following a combat-related injury.
- \$2,500 30 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration; does not include follow-up appointments.
- \$2,500 60 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration; does not include follow-up appointments.
- \$2,500 90 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration; does not include follow-up appointments.

11.2(2) Treatment or services must be provided in a location that is not the veteran’s home of record.
[ARC 0057C, IAB 4/4/12, effective 5/9/12]

801—11.3(35A) Eligible veterans.

11.3(1) For purposes of this program, the term “veteran” means:

a. A resident of this state who is or was a member of the national guard, reserve, or regular component of the armed forces of the United States who has served on active duty at any time after September 11, 2001, and, if discharged or released from service, was discharged or released under honorable conditions; or

b. A nonresident of this state who is or was a member of a national guard unit located in this state prior to alert for mobilization who has served on active duty at any time after September 11, 2001, was injured while serving in the national guard unit located in this state, is not eligible to receive a similar grant from another state for that injury, and, if discharged or released from service, was discharged or released under honorable conditions.

11.3(2) In addition to the requirements set out in subrule 11.3(1), an eligible veteran must meet all of the following conditions:

a. The veteran must have sustained a service-related injury in the line of duty, based upon the circumstances known at the time of evacuation or injury; in support of a named overseas operation; or in a hostile fire zone; and

b. The service-related injury was serious enough to require medical evacuation from the theater of operation to a military hospital or the injury required at least 30 consecutive days of hospitalization at a military hospital.

11.3(3) The veteran shall remain eligible for the grant after discharge from the military so long as the veteran continues to receive medical treatment or rehabilitation services for the specific injury or illness.

11.3(4) The commission may consider a request for a waiver of any of these requirements only pursuant to the provisions of Iowa Code section 17A.9A.
[ARC 9471B, IAB 4/20/11, effective 3/31/11; ARC 0057C, IAB 4/4/12, effective 5/9/12; ARC 4987C, IAB 3/11/20, effective 4/15/20]

801—11.4(35A) Notification and application procedures.

11.4(1) *Retroactive application to September 11, 2001.*

a. The department will accept a consolidated roster of eligible injured veterans from a “flag officer level command” or a central casualty notification agency of the responsible service component as long as the roster includes the following information for each veteran:

- (1) Veteran’s name, rank, and social security number.
- (2) Mailing address for check disbursement.
- (3) Telephone numbers, including day, evening, and cell phone.
- (4) Combat theater served.
- (5) Date on which veteran was medically evacuated from combat theater and verification of combat-related injury.
- (6) Date on which medical or rehabilitative treatment was terminated. If the veteran is still receiving treatment, “inpatient” or “outpatient” shall be noted on the form.
- (7) Contact information for the agency submitting the consolidated roster, including point of contact (POC), telephone numbers, and E-mail address.

b. A veteran filing for the grant under retroactive eligibility must submit an injured veteran grant application form along with supporting documents. Supporting documents needed to verify eligibility shall include copies of the following:

- (1) Military ID card;
- (2) DD214 (if the veteran has been discharged) or military orders to document service in a combat zone;
- (3) Medical records or military orders to document date of medical evacuation and periods of continued medical treatment or rehabilitation; and
- (4) Any document to establish Iowa residency at the time of injury, such as Iowa income tax forms, or to establish that the veteran is or was a member of a national guard unit located in this state prior to mobilization and was injured while serving in that national guard unit and is not eligible to receive a similar grant from another state for that injury.

A veteran may receive assistance in the application process by contacting the department office at (515)252-4698 or (800)838-4692 or by fax (515)727-3713.

11.4(2) *Process for present and future injured veterans.*

a. When the department receives official notification from a designated service office that a veteran has been medically evacuated from a combat zone, the department will confirm Iowa residency of the veteran or, in the case of a nonresident, confirm that the veteran is or was a member of a national guard unit located in this state prior to mobilization and gather the required data to disburse the first grant payment. The check will be made payable to the veteran and mailed or presented to the veteran or next of kin.

b. Grant payments will be stopped if the veteran is returned to duty or when medical or rehabilitative treatment is discontinued.

c. If an eligible combat-injured veteran is not medically evacuated, the 30 days of continuous treatment must occur within 12 months of the injury.

11.4(3) *Commission review.*

a. A three-person subcommittee of commissioners will review applications for those veterans not evacuated but requiring 30 days of consecutive treatment.

b. An applicant may appeal a grant award decision to the commission.

11.4(4) *Subsequent award.*

a. A seriously injured veteran meeting all other requirements of this rule may receive additional grants for subsequent, unrelated injuries that meet the requirements of this rule. Any subsequent,

unrelated injury shall be treated as if it were an initial injury for the purposes of determining eligibility or allotment.

b. Grants for veterans suffering subsequent, unrelated injuries after September 11, 2001, but prior to March 30, 2011, shall be payable, upon a showing that the veteran would have been eligible for payment had the subsequent, unrelated injury occurred on or after March 30, 2011.

[ARC 9471B, IAB 4/20/11, effective 3/31/11; ARC 0057C, IAB 4/4/12, effective 5/9/12; ARC 3341C, IAB 9/27/17, effective 11/1/17]

801—11.5(35A) Taxability. An injured veterans grant is exempt from Iowa income tax since the intent of the grant is to reimburse a veteran for family travel and lodging costs during the veteran's medical treatment and rehabilitation.

These rules are intended to implement Iowa Code section 35A.14 as amended by 2011 Iowa Acts, Senate File 402.

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CHAPTER 90
ADMINISTRATION OF THE BOILER AND PRESSURE VESSEL PROGRAM

[Prior to 1/14/98, see 347—Chs 41 to 49]

[Prior to 8/16/06, see 875—Chs 200, 202]

875—90.1(89) Purpose and scope. These rules institute administrative and operational procedures for implementation of Iowa Code chapter 89. An object shall not be considered “under pressure” and shall not be within the scope of Iowa Code chapter 89 when there is clear evidence that the manufacturer did not intend it to be operated at more than 3 psi and the object is operating at 3 psi or less. Jurisdiction is limited to objects, appurtenances, controls, safety devices, and equipment rooms as required by Iowa rules.

[ARC 0416C, IAB 10/31/12, effective 12/5/12; ARC 3903C, IAB 7/18/18, effective 9/1/18]

875—90.2(89,261,252J,272D) Definitions. To the extent they do not conflict with the definitions contained in Iowa Code chapter 89, the definitions in this rule shall be applicable to the rules contained in 875—Chapters 90 to 96.

“*Alteration*” means a change in a boiler or pressure vessel that substantially alters the original design requiring consideration of the effect of the change on the original design. It is not intended that the addition of nozzles smaller than an unreinforced opening size will be considered an alteration.

“*ANSI/ASME CSD-1*” means Control and Safety Devices for Automatically Fired Boilers.

“*Appurtenance*” means any item or equipment that is attached to the object and is part of the boiler external piping.

“*ASME*” means the American Society of Mechanical Engineers.

“*Boiler*” means a vessel in which water or other liquids are heated, steam or other vapors are generated, steam or other vapors are superheated, or any combination thereof, under pressure or vacuum by the direct application of heat. “Boiler” includes all temporary boilers.

“*Boiler external piping*” means all boiler piping and components as set forth in the scope of the edition of ASME B31.1 currently adopted by reference in Chapter 91.

“*Certificate of noncompliance*” means:

1. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J;
2. A certificate of noncompliance issued by the college student aid commission pursuant to Iowa Code chapter 261; or
3. A certificate of noncompliance issued by the centralized collection unit of the department of revenue pursuant to Iowa Code chapter 272D.

“*CFR*” means Code of Federal Regulations.

“*Construction or installation code*” means the applicable standard for construction or installation in effect at the time of installation.

“*Division*” means the division of labor services, unless another meaning is clear from the context.

“*Electric boilers*” means a power boiler, heating boiler, high or low temperature water boiler in which the source of heat is electricity.

“*External inspection*” means as complete an examination as can be reasonably made of the external surfaces and safety devices while the boiler or pressure vessel is in operation.

“*High temperature water boiler*” means a water boiler intended for operations at pressures in excess of 160 psig or temperatures in excess of 250 degrees F.

“*Hot water heating boiler*” means a boiler in which no steam is generated, from which hot water is circulated for heating purposes and then returned to the boiler, and which operates at a pressure not exceeding 160 psig or a temperature of 250 degrees F at the boiler outlet.

“*Hot water supply boiler*” means a boiler completely filled with water that furnishes hot water to be used externally to itself at pressures not exceeding 160 psig or at temperatures not exceeding 250 degrees F.

“*Institution of health and custodial care*” means any of the following:

1. A health care facility as defined by Iowa Code section 135C.1;

2. An assisted living program as defined by Iowa Code section 231C.2;
3. A boarding home as defined by Iowa Code section 135O.1;
4. A hospice that offers inpatient services in an institutional setting;
5. Any institution or facility in which persons are housed to receive medical, health, or other care or treatment; or
6. Any other institution or facility in which persons are housed to receive assistance with meeting personal needs or activities of daily living.

A facility or office that provides care and services only on an outpatient basis shall not be an “institution of health and custodial care.”

“*Internal inspection*” means as complete an examination as can be reasonably made of the internal and external surfaces of a boiler or pressure vessel while it is shut down and while manhole plates, handhole plates or other inspection opening closures are removed as required by the inspector.

“*ISO*” means International Standards Organization.

“*Labor commissioner*” means the labor commissioner or the commissioner’s designee.

“*Lap seam crack*” means a crack found in lap seams, extending parallel to the longitudinal joint and located either between or adjacent to rivet holes.

“*National Board*” means the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, Ohio 43229, whose membership is composed of the chief inspectors of jurisdictions who are charged with the enforcement of the provisions of boiler codes.

“*National Board Inspection Code*” means the Manual for Boiler and Pressure Vessel Inspectors (ANSI/NB 23) published by the National Board. Copies of the code may be obtained from the National Board.

“*Object*” means a boiler or pressure vessel.

“*Power boiler*” means a boiler in which steam or other vapor is generated at a pressure of more than 15 pounds per square inch or a water boiler intended for operation at pressures in excess of 160 pounds per square inch or temperatures in excess of 250 degrees Fahrenheit.

“*Process steam generator*” means a vessel or system of vessels comprised of one or more drums and one or more heat exchange surfaces as used in waste heat or heat recovery type steam boilers.

“*Psig*” means pounds per square inch gage.

“*Reinstallation*” means the process of disconnecting an object, moving it, and reconnecting it at the same location or a new location.

“*Relief valve*” means an automatic pressure-relieving device actuated by a static pressure upstream of the valve that opens further with the increase in pressure over the opening pressure and that is used primarily for liquid service.

“*Repair*” means work necessary to return a boiler or pressure vessel to a safe operating condition.

“*Rupture disk device*” means a nonreclosing pressure-relief device actuated by inlet static pressure and designed to function by the bursting of a pressure-containing disk.

“*Safety appliance*” shall include, but not be limited to:

1. Rupture disk device;
2. Safety relief valve;
3. Safety valve;
4. Temperature limit control;
5. Pressure limit control;
6. Gas switch;
7. Air switch; or
8. Any major gas train control.

“*Safety relief valve*” means an automatic, pressure-actuated relieving device suitable for use as a safety or relief valve, depending on application.

“*Safety valve*” means an automatic, pressure-relieving device actuated by the static pressure upstream of the valve and characterized by full opening pop action. The safety valve is used for gas or vapor service.

“*Special inspection*” means an inspection which is not required by Iowa Code chapter 89.

“*Temperature and pressure relief valve*” means a valve set to relieve at a designated temperature and pressure.

“*Unfired steam boiler*” means a vessel or system of vessels intended for operation at a pressure in excess of 15 psig for the purpose of producing and controlling an output of thermal energy.

“*Unfired steam pressure vessel*” means a vessel or container used for the containment of steam pressure either internal or external in which the pressure is obtained from an external source.

“*U.S. customary units*” means feet, pounds, inches and degrees Fahrenheit.

“*Water heater supply boiler*” means a closed vessel in which water is heated by combustion of fuels, electricity or any other source and withdrawn for use external to the system at pressure not exceeding 160 psig and shall include all controls and devices necessary to prevent water temperatures from exceeding 210 degrees F.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 9790B, IAB 10/5/11, effective 11/9/11; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 0739C, IAB 5/15/13, effective 6/19/13; ARC 1964C, IAB 4/15/15, effective 5/20/15; ARC 3903C, IAB 7/18/18, effective 9/1/18]

875—90.3(89) Iowa identification numbers. All objects shall be identified by an Iowa identification number. State inspectors and special inspectors shall assign identification numbers as directed by the division to all jurisdictional objects that lack numbers. Identification numbers shall be attached in plain view to the object using one of the following methods:

1. A yellow sticker 2 inches by 3 inches affixed to the object and bearing the number.
2. A metal tag 1 inch by 2½ inches affixed to the object and bearing the number.
3. Numbers at least 5/16 of an inch high and stamped directly on the object.

875—90.4(89) National Board registration. Rescinded IAB 11/18/09, effective 1/1/10.

875—90.5(89) Preinspection owner or user preparation.

90.5(1) Preparation of objects. Each owner or user shall ensure that each object covered by Iowa Code chapter 89 is prepared for inspection pursuant to this rule.

90.5(2) Confined space and lockout, tagout procedures.

a. It is the responsibility of the owner or user to assess all objects for compliance with the confined space and lockout, tagout standards pursuant to 29 CFR 1910.146 and 1910.147. If an object is a non-permit-required confined space or a permit-required confined space as defined by 29 CFR 1910.146, the owner or user must comply with all applicable requirements of 29 CFR 1910.146 and 1910.147 in preparing the object for inspection.

b. It is the duty of the owner or user to inform any inspector of the owner’s or user’s confined space entry and lockout, tagout procedures and supply to the inspector all information necessary to assess whether the confined space is safe for entry. It is the right of an inspector to verify any of the information supplied.

c. If the requirements of 29 CFR 1910.146 and 1910.147 are not met, the inspector shall not enter the space. If there is a breach of the procedure or the procedure is inconsistent with 29 CFR 1910.146 or 1910.147, the inspection process shall cease until the space is reassessed and determined to be safe or the procedure is rewritten in a manner consistent with the standards. No inspector shall violate the owner’s or user’s confined space or lockout, tagout procedures in making an inspection.

d. The owner or user shall have all objects locked and tagged, as applicable, prior to the inspector’s entry for inspection or testing.

e. For entry into a permit-required confined space, the owner or user shall provide the necessary equipment such as air monitors and a qualified attendant who has received all the information relevant to the entry.

90.5(3) Hydrostatic tests. The owner or user shall prepare for and apply a hydrostatic test, whenever necessary, on the date specified by the inspector, which date shall be not less than seven days after the date of notification.

90.5(4) Boilers. A boiler shall be prepared for internal inspection in the following manner:

- a. Fluid shall be drawn off and the boiler washed thoroughly.

b. Manhole and handhole plates, washout plugs and inspection plugs in water columns shall be removed as required by the inspector. The furnace and combustion chambers shall be thoroughly cooled and cleaned.

c. All grates of internally fired boilers shall be removed.

d. Brickwork shall be removed as required by the inspector in order to determine the condition of the boiler, header, furnace, supports or other parts.

e. Low-water fuel cutoff controls shall be opened or removed to allow for visual inspection.

90.5(5) Pressure vessels. The extent of inspection preparation for a pressure vessel will vary. If the inspection is to be external only, advance preparation is not required other than to afford reasonable access to the vessel. For combined internal and external inspections of small vessels of simple construction handling air, steam, nontoxic or nonexplosive gases or vapors, minor preparation is required, including affording reasonable means of access and removing manhole plates and inspection openings. In other cases, preparation shall include removing the internal fittings and appurtenances to permit satisfactory inspection of the interior of the vessel if required by the inspector.

90.5(6) Removal of covering or brickwork to permit inspection. If the object is jacketed so that the longitudinal seams of shells, drums, or domes cannot be seen, sufficient jacketing, setting wall, or other form of casing or housing shall be removed to permit reasonable inspection of the seams and so that the size of rivets, pitch of the rivets, and other data necessary to determine the safety of the object may be obtained, providing the information cannot be determined by other means. Brickwork shall be removed as required by the inspector in order to determine the condition of the boiler, header, furnace, supports or other parts.

90.5(7) Improper preparation for inspection. If an object has not been properly prepared for an internal inspection, or if the owner or user fails to comply with the requirements for hydrostatic tests as set forth in this chapter, the inspector may decline to make the inspection or test, and the inspection certificate shall be withheld until the owner or user complies with the requirements.

[ARC 9082B, IAB 9/22/10, effective 10/27/10]

875—90.6(89) Inspections.

90.6(1) General. All boilers and unfired steam pressure vessels covered by Iowa Code chapter 89 shall be inspected according to the requirements of the National Board Inspection Code (2019), which is hereby adopted by reference. A division inspector or special inspector must perform the inspections.

90.6(2) Schedule.

a. All required inspections must be performed according to the schedule set forth in Iowa Code section 89.3, unless an exception is set forth in this rule.

b. Except for inspections of unfired steam pressure vessels operating in excess of 15 pounds per square inch and low pressure steam boilers, each certificate inspection must be performed within a 60-day period prior to the expiration date of the operating certificate. Modification of this 60-day period will be permitted only upon written application showing just cause for waiver of the 60-day period.

c. Special inspections may be conducted at any time mutually agreed to by the division and the object's owner or user.

90.6(3) Inspections conducted by special inspectors. Special inspectors shall provide copies of the completed report to the insured and to the division within 30 days of the inspection. The reports shall list all adverse conditions and all requirements, if any. If the special inspector has not notified the division of the inspection results within 30 days of the expiration of an operating certificate, the division may conduct the inspection.

90.6(4) Type of inspection. The inspection shall be an internal inspection when required; otherwise, it shall be as complete an external inspection as possible. Conditions including, but not limited to, the following may also be the basis for an internal inspection:

a. Visible metal or insulation discoloration due to excessive heat.

b. Visible distortion of any part of the pressure vessel.

c. Visible leakage from any pressure-containing boundary.

- d. Any operating records or verbal reports of a vessel being subjected to pressure above the nameplate rating or to a temperature above or below the nameplate design temperature.
- e. A suspected or known history of internal corrosion or erosion.
- f. Evidence or knowledge of a vessel having been subjected to external heat from a fire.
- g. A welded repair not documented as required.
- h. Evidence of an accident, incident or malfunction that could affect or may have resulted from a problem with the object's integrity.

90.6(5) *Internal inspections for unfired steam pressure vessels operating at more than 15 pounds per square inch.* The commissioner may require an internal inspection of an unfired steam pressure vessel operating in excess of 15 psi when an inspector observes any deviation from these rules, Iowa Code chapter 89, the construction code, the installation code, or the National Board Inspection Code.

90.6(6) *Inspection of inaccessible parts.* When, in the opinion of the inspector, as a result of conditions disclosed at the time of inspection, it is advisable to remove the interior or exterior lining, covering, or brickwork to expose certain parts of the vessel not normally visible, the owner or user shall remove such material to permit proper inspection and thickness measurement of any part of the vessel. Nondestructive examination is acceptable.

90.6(7) *Imminent danger.* If the labor commissioner determines that continued operation of an object constitutes an imminent danger that could seriously injure or cause death to any person, notice to immediately cease operation of that object shall be posted by the labor commissioner. Upon such notice, the owner shall immediately begin the necessary steps to cease operation of the object. The object shall not be used until the necessary repairs have been completed and the object has passed inspection. Operation of an object in violation of this subrule may result in further legal action pursuant to Iowa Code sections 89.11 and 89.13.

90.6(8) *Internal inspections on a four-year cycle based on process safety management compliance.* The owner shall demonstrate compliance with the requirements set forth in Iowa Code section 89.3(5) "a"(4)(b) by annually submitting to the labor commissioner a notarized affidavit. The affidavit shall be in a format approved by the labor commissioner and shall be signed by the owner or an officer of the company.

90.6(9) *Internal inspection on a four-year cycle for utility objects.* An object that meets the criteria of this subrule shall be inspected internally at least once every four years and externally every year. If at any time the object or the owner no longer meets the criteria of this subrule, internal inspections shall be performed on a two-year cycle.

a. The object is owned and operated by an electric public utility subject to rate regulation under Iowa Code chapter 476.

b. The object and the owner meet all the requirements for a two-year internal inspection interval as set forth in Iowa Code section 89.3, subsection 4.

c. If the object is shut down for a period sufficient to allow safe entry, and more than two years have passed since the last internal inspection, the owner shall notify the labor commissioner of the outage and shall schedule an internal inspection.

d. If the labor commissioner determines that an earlier inspection is necessary, the owner shall prepare the object for inspection pursuant to rule 875—90.5(89).

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 1189C, IAB 11/27/13, effective 1/1/14; ARC 1634C, IAB 10/1/14, effective 11/5/14; ARC 1964C, IAB 4/15/15, effective 5/20/15; ARC 2403C, IAB 2/17/16, effective 4/1/16; ARC 4977C, IAB 3/11/20, effective 4/15/20]

875—90.7(89) Fees.

90.7(1) *Special inspector commission fee.* A \$55 fee shall be paid annually to the commissioner to obtain a special inspector commission pursuant to Iowa Code section 89.7.

90.7(2) *Certificate fee.* A \$40 fee shall be paid for each one-year certificate, an \$80 fee shall be paid for each two-year certificate, and a \$160 fee shall be paid for each four-year certificate.

90.7(3) *Fees for inspection.* An inspection fee for each object inspected by a division inspector shall be paid by the appropriate party as follows:

- a. A \$55 fee for each water heater supply boiler.

b. A \$95 fee for each boiler, other than a water heater supply boiler, having a working pressure up to and including 450 pounds per square inch or generating between 20,000 and 100,000 pounds of steam per hour.

c. A \$215 fee for each boiler, other than a water heater supply boiler, having a working pressure in excess of 450 pounds per square inch and generating in excess of 100,000 pounds of steam per hour.

d. A \$55 fee for each pressure vessel, such as steam stills, tanks, jacket kettles, sterilizers and all other reservoirs having a working pressure of 15 pounds or more per square inch.

e. An additional fee will be charged if, upon the request of an owner or user, the labor commissioner agrees to any non-routine schedule for an inspection outside of normal business hours, a special inspection, or a site visit. The additional fee will be calculated at a rate of \$200 per hour, including travel time, with a minimum charge of \$400.

f. If a boiler or pressure vessel has to be reinspected, there shall be another inspection fee as specified above.

90.7(4) Fees for attempted inspections. A \$35 fee shall be charged for each attempt by a division inspector to conduct an inspection which is not completed through no fault of the division.

[ARC 7863B, IAB 6/17/09, effective 7/1/09; ARC 8081B, IAB 8/26/09, effective 9/30/09; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 1422C, IAB 4/16/14, effective 5/21/14; ARC 4733C, IAB 10/23/19, effective 11/27/19]

875—90.8(89) Certificate. No boiler or pressure vessel shall be operated without a current, valid certificate to operate. A certificate to operate shall not be issued until the boiler or pressure vessel is in compliance with the applicable rules and all fees have been paid. The current certificate to operate or a copy of the current certificate to operate shall be conspicuously posted in the room where the object is installed.

[ARC 1964C, IAB 4/15/15, effective 5/20/15]

875—90.9(89,252J,261) Special inspector commissions.

90.9(1) Definition of “reputable insurance company.” As used in this rule, “reputable insurance company” means a company recognized by the Iowa insurance division as a licensed insurer, a risk retention group, an alien surplus lines insurer, or a surplus lines insurer.

90.9(2) Application. A person applying for a commission shall complete, sign, and submit to the division with the required fee the form entitled “Application for Boiler and Pressure Vessel Special Inspector Commission” provided by the division. Additionally, the applicant shall submit a copy of the applicant’s current National Board work card with each application.

90.9(3) Expiration. The commission is for no more than one year and ceases when the special inspector leaves employment with the insurance company, or when the commission is suspended or revoked by the labor commissioner. Each commission shall expire no later than June 30 of each year.

90.9(4) Changes. The special inspector shall notify the division at the time any of the information on the form or attachments changes.

90.9(5) Denials. The labor commissioner may refuse to issue or renew a special inspector’s commission for failure to complete an application package, if the applicant or inspector does not hold a National Board commission, or for any reason listed in subrules 90.9(7) to 90.9(9).

90.9(6) Investigations. Investigations shall take place at the time and in the places the labor commissioner directs. The labor commissioner may investigate for any reasonable cause. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice.

90.9(7) Reasons for probation. The labor commissioner may issue a notice of commission probation when an investigation reasonably reveals that the special inspector does not represent a reputable insurance company or the special inspector filed inaccurate reports.

90.9(8) Reasons for suspension. The labor commissioner may issue a notice of commission suspension when an investigation reasonably reveals the following:

- a.* The special inspector failed to submit and report inspections on a timely basis;
- b.* The special inspector abused the special inspector’s authority;
- c.* The special inspector misrepresented self as a state inspector or a state employee;

- d. The special inspector used commission authority for inappropriate personal gain;
- e. The special inspector failed to follow the division's rules for inspection of object repairs, alterations, construction, installation, or in-service inspection;
- f. The special inspector committed numerous violations as described in subrule 90.9(7);
- g. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;
- h. The National Board revoked or suspended the special inspector's work card;
- i. The division received a certificate of noncompliance;
- j. The special inspector failed to take appropriate disciplinary actions against a subordinate special inspector who has committed repeated acts or omissions listed in paragraphs "a" to "h" of this subrule; or
- k. The special inspector does not represent a reputable insurance company.

90.9(9) Reasons for revocation. The labor commissioner may issue a notice of revocation of a special inspector's commission when an investigation reveals any of the following:

- a. The special inspector filed a misleading, false or fraudulent report;
- b. The special inspector failed to perform a required inspection;
- c. The special inspector failed to file a report or filed a report which was not in accordance with the provisions of applicable standards;
- d. The special inspector failed to notify the division in writing of any accident involving an object;
- e. The special inspector committed repeated violations as described in subrule 90.9(8);
- f. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;
- g. The special inspector instructed, ordered, or otherwise encouraged a subordinate special inspector to perform the acts or omissions listed in paragraphs "a" to "f" of this subrule;
- h. The National Board revoked or suspended the special inspector's work card;
- i. The division received a certificate of noncompliance; or
- j. The special inspector does not represent a reputable insurance company.

90.9(10) Procedures. The following procedures shall apply except in the event of revocation or suspension due to receipt of a certificate of noncompliance. In instances involving receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J, 261, or 272D shall apply.

a. *Notice of actions.* The labor commissioner shall serve a notice on the special inspector by certified mail to an address listed on the commission application form or by other service as permitted by Iowa Code chapter 17A. A copy shall be sent to the insurance company employing the special inspector.

b. *Contested cases.* The special inspector shall have 20 days to file a written notice of contest with the labor commissioner. If the special inspector does not file a written contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.

c. *Hearing procedures.* The hearing procedures in 875—Chapter 1 shall govern.

d. *Emergency suspension.* Pursuant to Iowa Code section 17A.18A, if the labor commissioner finds that public health, safety or welfare imperatively requires emergency action because a special inspector failed to comply with applicable laws or rules, the special inspector's commission may be summarily suspended.

e. *Probation period.* A special inspector may be placed on probation for a period not to exceed one year for each incident causing probation.

f. *Suspension period.* A special inspector's commission may be suspended up to five years for each incident causing a suspension.

g. *Revocation period.* A special inspector's commission that has been revoked shall not be reinstated for five years.

h. *Concurrent actions.* Multiple actions may proceed at the same time against any special inspector.

i. Revoked or suspended commissions. Within five business days of final agency action revoking or suspending a special inspector commission, the special inspector shall forfeit the special inspector's commission card to the labor commissioner.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 4734C, IAB 10/23/19, effective 11/27/19]

875—90.10(89) Quality reviews, surveys and audits.

90.10(1) An entity that manufactures or repairs boilers, pressure vessels or related equipment may request quality reviews, surveys or audits from certifying organizations such as the ASME or the National Board. The division is authorized to conduct the quality reviews, surveys or audits. If the division performs the service, the manufacturer or repairer shall pay all applicable expenses.

90.10(2) Quality reviews, surveys and audits for certification to the National Board or ASME standards shall be conducted only by a person or organization designated by the labor commissioner. Any person or organization seeking this designation on behalf of the division shall provide documented evidence of training, examination, experience, and certification for the type of reviews, surveys and audits to be performed. The labor commissioner shall have final authority to determine qualifications and designations.

a. Assessing quality programs. The division recognizes the ASME and the National Board as qualified designees for conducting quality reviews, surveys and audits that lead to ASME or National Board program certification.

b. ISO 9000 assessments. The division recognizes the ASME and the National Board:

- (1) To be acceptable ISO 9000 registrars of quality systems for boilers and pressure vessels and the related pressure-technology equipment industry;
- (2) To certify auditors and lead auditors to the requirements of ISO 10011-2 1991(E), Annex A; and
- (3) To conduct ISO 9000 assessments for the boiler, pressure vessel, and related pressure-technology equipment industry.

875—90.11(89) Reporting requirements.

90.11(1) *Control and safety device reports.* Documentation required by this subrule shall be kept on site and shall be available for inspection.

a. The requirements of this subrule do not apply to:

- (1) Rescinded IAB 7/18/18, effective 9/1/18.
- (2) An object within the scope of 875—Chapter 96;
- (3) A hot water supply boiler covered by ASME Section IV, Part HLW; or
- (4) A boiler with a fuel input rating greater than or equal to 12,500,000 Btu per hour, falling within the scope of NFPA 85, Boiler and Combustion Systems Hazards Code.

b. The installer shall complete a Manufacturer's/Installing Contractor's Report for ASME CSD-1 (CSD-1 report) for each newly installed or reinstalled object.

c. A person who installs a new burner, new gas train, or new controller on an object shall complete a CSD-1 report.

d. A person who replaces a part or component of an object shall complete the relevant portions of the CSD-1 report unless the replacement satisfies the design specifications. A copy of an invoice containing the same information as the relevant portions of the CSD-1 report is an acceptable alternative.

90.11(2) *Reporting repairs and alterations.* If the National Board Inspection Code requires that an R-1 Report of Repair or an R-2 Report of Alteration be filed with the National Board, a copy of the National Board form must be simultaneously filed with the labor commissioner.

90.11(3) *Reporting explosions and other incidents.*

a. The following definitions apply to this subrule.

"Incident" means the explosion of a covered object or other failure of a component of a covered object causing injury or acute illness.

"Injury" means a personal injury requiring professional medical care or causing disability exceeding one day.

b. The owner or user of a covered object shall notify the commissioner of an incident. A special inspector investigating an incident shall notify the owner or user of this reporting requirement.

c. Incident reports shall be made by calling (515)725-5609 or (515)725-5610. If the incident occurs during normal division operating hours, notification shall occur before close of business on that day. If the incident occurs when the division office is closed, the notification shall occur no later than close of business on the next division business day. Division hours are 8 a.m. to 4:30 p.m., Monday through Friday, except state holidays.

d. At the request of the commissioner, a person who submits a report pursuant to this subrule shall also submit a written report that includes the state identification number of the object, name of the owner of the object, and description of the incident.

e. The removal of any part of the damaged object from the premises is forbidden until permission to do so is granted by the state inspector or special inspector who investigated the incident.

f. When an incident involves the failure or destruction of any part of the object, the use of the object is forbidden until it has been made safe and it has passed an inspection by the state inspector or special inspector who investigated the incident.

[ARC 2589C, IAB 6/22/16, effective 7/27/16; ARC 3903C, IAB 7/18/18, effective 9/1/18; ARC 4733C, IAB 10/23/19, effective 11/27/19]

875—90.12(89) Publications available for review. Pursuant to Iowa Code section 89.5, subsection 3, the standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa.

875—90.13(89) Notice prior to installation. Written notice of intent to install objects subject to the jurisdiction of Iowa Code chapter 89 shall be provided to the labor commissioner at least ten days before installation. Written notice shall be accomplished by completing and submitting to the labor commissioner either:

1. The form designated by the labor commissioner, or
2. The National Board's Boiler Installation Report, I-1.

875—90.14(89) Temporary boilers. A certificate to operate a temporary boiler shall expire one year from the date of issuance or when the temporary boiler is disconnected. Inspections on temporary boilers that remain in one location longer than one year shall be performed according to the inspection schedule of Iowa Code section 89.3. A temporary boiler that is installed at a different location less than a year since the prior internal inspection of the boiler shall be subjected to a hydrostatic test pursuant to the National Board Inspection Code or to an internal inspection, at the discretion of the inspector.

875—90.15(89) Conversion of a power boiler to a low-pressure boiler. The following requirements apply to the conversion of a power boiler to a low-pressure boiler. The owner shall comply with the requirements of subrule 90.15(1) for each conversion. In addition, the owner shall comply with the requirements of subrule 90.15(2) if the converted object will be located outside of a place of public assembly or with the requirements of subrule 90.15(3) if the converted object will be located in a place of public assembly.

90.15(1) General requirements.

a. The owner shall provide to the labor commissioner written notice of intent to convert a power boiler to a low-pressure boiler prior to conversion. The required form for a notice of conversion is available at iowaboilers.gov. At a minimum the notice shall contain the following:

- (1) Address, uses, and owner of the building where the boiler is located.
- (2) The Iowa identification number assigned to the boiler.
- (3) Name and contact information for the person completing the notice.
- (4) Name and contact information for the contractor or other person planning to perform the conversion.

b. Pressure controls shall not exceed 14 pounds per square inch.

c. All boiler controls shall comply with ASME CSD-1.

d. Safety valves and safety relief valves shall be manufactured in accordance with a national or international standard.

e. One or more spring-pop safety valves meeting the following requirements shall be installed on each steam boiler:

- (1) The valve shall be adjusted and sealed to discharge at a pressure not to exceed 15 psig.
- (2) The valve capacity shall be certified by the National Board.

f. The converted boiler shall be subject to post-conversion external inspection to ensure that the requirements of this rule are met.

90.15(2) *Boilers located outside places of public assembly.* A power boiler that was converted to a low-pressure boiler and that is located outside of a place of public assembly shall not be converted back to a power boiler unless the following requirements are met:

- a. The owner shall notify the labor commissioner at least ten days prior to converting the boiler.
- b. The owner shall comply with the editions of ASME Section I and CSD-1 in effect at the time of the second conversion.
- c. The owner shall comply with the version of 875—Chapter 92 in effect at the time of the second conversion.

90.15(3) *Boilers located in places of public assembly.* A power boiler converted to a low-pressure boiler that is located in a place of public assembly shall comply with 875—Chapter 94.

[ARC 9232B, IAB 11/17/10, effective 12/22/10; ARC 3635C, IAB 2/14/18, effective 3/21/18]

These rules are intended to implement Iowa Code chapters 17A, 89, 252J, 261, and 272D.

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[Filed ARC 0319C (Notice ARC 0207C, IAB 7/11/12), IAB 9/5/12, effective 10/10/12]

[Filed ARC 0416C (Notice ARC 0322C, IAB 9/5/12), IAB 10/31/12, effective 12/5/12]

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[Filed ARC 1422C (Notice ARC 1333C, IAB 2/19/14), IAB 4/16/14, effective 5/21/14]

[Filed ARC 1634C (Notice ARC 1550C, IAB 7/23/14), IAB 10/1/14, effective 11/5/14]

[Filed ARC 1964C (Notice ARC 1798C, IAB 12/24/14), IAB 4/15/15, effective 5/20/15]

[Filed ARC 2403C (Notice ARC 2251C, IAB 11/25/15), IAB 2/17/16, effective 4/1/16]

[Filed ARC 2589C (Notice ARC 2419C, IAB 2/17/16), IAB 6/22/16, effective 7/27/16]

[Filed ARC 3635C (Notice ARC 3504C, IAB 12/20/17), IAB 2/14/18, effective 3/21/18]

[Filed ARC 3903C (Notice ARC 3807C, IAB 5/23/18), IAB 7/18/18, effective 9/1/18]

[Filed ARC 4733C (Notice ARC 4564C, IAB 7/31/19), IAB 10/23/19, effective 11/27/19]

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[Filed ARC 4977C (Notice ARC 4863C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]

[◇] Two or more ARCs

¹ Date corrected IAC Supp. 3/26/08

CHAPTER 91
GENERAL REQUIREMENTS FOR ALL OBJECTS

[Prior to 1/14/98, see 347—Chs 41 to 49]

[Prior to 8/16/06, see 875—Ch 203]

875—91.1(89) Codes and code cases adopted by reference.

91.1(1) *ASME boiler and pressure vessel codes adopted by reference.* The ASME Boiler and Pressure Vessel Code (2019) is adopted by reference. Regulated objects shall be designed and constructed in accordance with the ASME Boiler and Pressure Vessel Code (2019) except for objects that meet one of the following criteria:

- a. An object with an ASME stamp and National Board Registration that establish compliance with an earlier version of the ASME Boiler and Pressure Vessel Code;
- b. A miniature boiler installed before March 31, 1967;
- c. A power boiler or unfired steam pressure vessel installed before July 4, 1951; or
- d. A steam heating boiler, hot water heating boiler, or hot water supply boiler installed before July 1, 1960.

91.1(2) *ASME code cases.* If the manufacturer of an object listed ASME Code Case 2668-1, 2760, 2764-1, or 2869 on the manufacturer's data report for the object and the object is otherwise in compliance with all applicable provisions, the object is in compliance with these rules.

91.1(3) *Inspection code adopted by reference.* The National Board Inspection Code (2019) is adopted by reference, and reinstallations, installations, alterations, and repairs after April 15, 2020, shall comply with it.

91.1(4) *Electric code adopted by reference.* The National Electrical Code (2020) is adopted by reference, and reinstallations and installations after April 15, 2020, shall comply with it.

91.1(5) *Piping codes adopted by reference.* The Power Piping Code, ASME B31.1 (2018), and the Building Services Piping Code, ASME B31.9 (2017), are adopted by reference, and reinstallations and installations after April 15, 2020, shall comply with them up to and including the first valve.

91.1(6) *Control and safety device code adopted by reference.* Controls and Safety Devices for Automatically Fired Boilers (CSD-1) (2018) is adopted by reference, and reinstallations and installations after April 15, 2020, shall comply with it. Reporting requirements concerning CSD-1 are set forth at rule 875—90.11(89).

91.1(7) *Mechanical code adopted by reference.* Excluding Section 701.1, Chapters 2 and 7 of the International Mechanical Code (IMC) (2018) are adopted by reference, and installations and reinstallations after September 1, 2018, shall comply with them.

91.1(8) *Oil burning equipment code adopted by reference.* National Fire Protection Association Standard for the Installation of Oil Burning Equipment, NFPA 31 (2016), is adopted by reference, and installations and reinstallations after September 1, 2018, shall comply with it.

91.1(9) *Fuel gas code adopted by reference.* National Fire Protection Association National Fuel Gas Code, NFPA 54 (2018), is adopted by reference, and installations and reinstallations after September 1, 2018, shall comply with it.

91.1(10) *Liquefied petroleum gas code adopted by reference.* National Fire Protection Association Liquefied Petroleum Gas Code, NFPA 58 (2020), is adopted by reference, and installations and reinstallations after April 15, 2020, shall comply with it.

91.1(11) *Boiler and combustion systems hazards code adopted by reference.* National Fire Protection Association Boiler and Combustion Systems Hazards Code, NFPA 85 (2019), is adopted by reference, and installations and reinstallations after April 15, 2020, shall comply with it.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 8590B, IAB 3/10/10, effective 4/14/10; ARC 9232B, IAB 11/17/10, effective 12/22/10; ARC 9790B, IAB 10/5/11, effective 11/9/11; ARC 0319C, IAB 9/5/12, effective 10/10/12; ARC 0416C, IAB 10/31/12, effective 12/5/12; ARC 1011C, IAB 9/18/13, effective 10/31/13; ARC 1964C, IAB 4/15/15, effective 5/20/15; ARC 2403C, IAB 2/17/16, effective 4/1/16; ARC 2589C, IAB 6/22/16, effective 7/27/16; ARC 3635C, IAB 2/14/18, effective 3/21/18; ARC 3903C, IAB 7/18/18, effective 9/1/18; ARC 4303C, IAB 2/13/19, effective 3/20/19; ARC 4977C, IAB 3/11/20, effective 4/15/20]

875—91.2(89) Safety appliance. No person shall remove, disable or tamper with a required safety appliance except for the purpose of repair or inspection. An object shall not be operated unless all applicable safety appliances are properly functional and operational.

875—91.3(89) Pressure-reducing valves. Rescinded **ARC 3903C**, IAB 7/18/18, effective 9/1/18.

875—91.4(89) Blowoff equipment. The blowdown from an object that enters a sanitary sewer system or blowdown that is considered a hazard to life or property shall pass through blowoff equipment that will reduce pressure and temperature. The temperature of the water leaving the blowoff equipment shall not exceed 150 degrees Fahrenheit. If the local jurisdiction has a temperature limit of less than 150 degrees Fahrenheit, the temperature of the water leaving the blowoff equipment shall comply with the limit set by the local jurisdiction. The pressure of the water leaving the blowoff equipment shall not exceed 5 psig. The blowoff piping and fittings between the object and the blowoff tank shall comply with the construction or installation code. All materials used in the fabrication of object blowoff equipment shall comply with the construction or installation code. All blowoff equipment shall be equipped with openings to facilitate cleaning and inspection.

[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—91.5(89) Location of discharge piping outlets. The discharge from safety valves, safety relief valves, blowoff pipes and other outlets shall be so arranged that there will be no danger of scalding personnel. When the safety valve or temperature and pressure relief valve discharge is piped away from the object to the point of discharge, provision shall be made for properly draining the piping. The size of the discharge piping shall not be reduced from the size of the relief valve.

875—91.6(89) Pipe, valve, and fitting requirements. Pipes, valves, and fittings subject to the effects of galvanic action shall not be used on objects covered by these rules. Dielectric fittings shall be used where dissimilar metals are joined.

[**ARC 8283B**, IAB 11/18/09, effective 1/1/10; **ARC 3903C**, IAB 7/18/18, effective 9/1/18]

875—91.7(89) Electric steam generator. Rescinded **ARC 0319C**, IAB 9/5/12, effective 10/10/12.

875—91.8(89) Alterations, retrofits and repairs to objects. Rescinded **ARC 0319C**, IAB 9/5/12, effective 10/10/12.

875—91.9(89) Boiler door latches. Rescinded **ARC 0319C**, IAB 9/5/12, effective 10/10/12.

875—91.10(89) Clearance.

91.10(1) All objects installed prior to September 20, 2006, shall be so located that adequate space is provided for the proper operation, inspection, and necessary maintenance and repair of the object and its appurtenances.

91.10(2) This subrule applies to installations and reinstallations after September 20, 2006. Minimum clearance on all sides of objects shall be 24 inches, or the manufacturer's recommended service clearances if they allow sufficient room for inspection. Where a manufacturer identifies in the installation manual or any other document that the unit requires more than 24 inches of service clearance, those dimensions shall be followed. Manholes shall have five feet of clearance between the manhole opening and any wall, ceiling or piping that would hinder entrance or exit from the object.

875—91.11(89) Fall protection. Safe access to all necessary parts of boilers over eight feet tall shall be provided by a runway platform or fall protection system consistent with the requirements below.

91.11(1) Runway platform. A steel runway platform in compliance with the criteria of 29 CFR 1910.23 and 1910.27 shall be installed across the tops of objects or at some other convenient level for the purpose of affording safe access. All runways shall have at least two means of exit remotely located from each other.

91.11(2) Fall protection system. A fall protection system shall be in compliance with the requirements of 29 CFR 1910.132.

875—91.12(89) Exit from rooms containing objects. All rooms exceeding 500 square feet of floor area and containing one or more objects having a fuel-burning capacity of 1 million Btu's shall have two means of exit remotely located from each other on each level.

875—91.13(89) Air and ventilation.

91.13(1) Notice concerning other rules. The division and the Iowa department of public safety both enforce requirements concerning air and ventilation. Objects that are covered by both sets of rules must comply with both sets of rules.

91.13(2) Documentation. Documentation of compliance with any requirement of this rule shall be maintained in the boiler room. However, it is not necessary to maintain documentation of the louvered area.

91.13(3) National combustion air standards.

a. Installations and reinstallations. Installations and reinstallations shall comply with the edition of NFPA 31, NFPA 54, NFPA 58, NFPA 85, or IMC currently adopted at rule 875—91.1(89) or with the Iowa combustion air standard in subrule 91.13(4). However, compliance with one of the listed NFPA codes constitutes compliance with this rule only if the object burns the fuel covered by the NFPA.

b. Existing objects. An adequate supply of combustion air shall be maintained for all objects while in operation. Compliance with the current edition of NFPA 31, NFPA 54, NFPA 58, NFPA 85, or IMC as adopted at rule 875—91.1(89) or with subrule 91.13(4) constitutes compliance with this rule. Compliance with an earlier edition of NFPA 31, NFPA 54, NFPA 58, NFPA 85, or IMC constitutes compliance with this rule. However, compliance with one of the listed NFPA codes constitutes compliance with this rule only if the object burns the fuel covered by the NFPA. Compliance with an earlier version of Iowa's combustion air rule constitutes compliance with this rule. Earlier versions of Iowa's combustion air rule are available from the board's staff upon request.

91.13(4) Iowa combustion air standard. A permanent source of outside air shall be provided for each room to permit satisfactory combustion of fuel and ventilation if necessary under normal operations. The minimum ventilation for coal, gas, or oil burners in rooms containing objects is based on the Btu's per hour, required air, and louvered area. The minimum net louvered area shall not be less than 1 square foot. The following table shall be used to determine the net louvered area in square feet:

INPUT (Btu's per hour)	MINIMUM AIR REQUIRED (cubic feet per minute)	MINIMUM LOUVERED AREA (net square feet)
500,000	125	1.0
1,000,000	250	1.0
2,000,000	500	1.6
3,000,000	750	2.5
4,000,000	1,000	3.3

INPUT (Btu's per hour)	MINIMUM AIR REQUIRED (cubic feet per minute)	MINIMUM LOUVERED AREA (net square feet)
5,000,000	1,200	4.1
6,000,000	1,500	5.0
7,000,000	1,750	5.8
8,000,000	2,000	6.6
9,000,000	2,250	7.5
10,000,000	2,500	8.3

When mechanical ventilation is used, the supply of combustion and ventilation air to the objects and the firing device shall be interlocked with the fan so the firing device will not operate with the fan off. The velocity of the air through the ventilating fan shall not exceed 500 feet per minute, and the total air delivered shall be equal to or greater than shown above.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 3635C, IAB 2/14/18, effective 3/21/18]

875—91.14(89) Condensate return tank. Condensate return tanks shall be equipped with at least two vents or a vent and overflow pipe to protect against a loose float plugging a single connection.

875—91.15(89) Conditions not covered. Any condition not governed by these rules shall be governed by the construction or installation code.

875—91.16(89) Nonstandard objects. Rescinded IAB 3/12/08, effective 4/16/08.

875—91.17(89) English language and U.S. customary units required. All documentation supplied for the unit including but not limited to the manufacturers' data report, drawings, parts lists, installation manuals, and operating manuals shall be in English, and all measurements shall be in U.S. customary units. All pressure gages, thermometers and other controls and safety devices shall also be in U.S. customary units.

875—91.18(89) National Board registration. Except for cast iron boilers and cast aluminum boilers, all objects shall be registered with the National Board.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 3903C, IAB 7/18/18, effective 9/1/18]

875—91.19(89) ASME stamp. All objects shall bear the appropriate ASME stamp. Objects shall not be utilized in a manner inconsistent with the stamp.

[ARC 8283B, IAB 11/18/09, effective 1/1/10; ARC 3903C, IAB 7/18/18, effective 9/1/18]

875—91.20(89) CSD-1 reports and related documentation. Rescinded ARC 2589C, IAB 6/22/16, effective 7/27/16.

These rules are intended to implement Iowa Code chapter 89.

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