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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

Engineering and Land Surveying Examining Board[193C]

Replace Chapter 3

Real Estate Commission[193E]

Replace Chapter 19

Education Department[281]

Replace Analysis

Replace Chapter 36

Replace Chapter 43

Remove Reserved Chapters 81 and 82

Insert Chapter 81 and Reserved Chapter 82

Replace Chapter 96

Human Services Department[441]

Replace Chapter 78

Environmental Protection Commission[567]

Replace Chapter 23

Professional Licensure Division[645]

Replace Chapter 124

Revenue Department[701]

Replace Chapter 71

Secretary of State[721]

Replace Analysis

Replace Chapters 21 and 22

Replace Chapter 26

Veterans Affairs, Iowa Department of[801]

Replace Chapter 11

CHAPTER 3
APPLICATION AND RENEWAL PROCESS

[Prior to 11/14/01, see 193C—Chapter 1]

193C—3.1(542B) General statement. A person requesting to be licensed as a professional engineer or land surveyor shall submit a completed, standardized, notarized application form, which may be obtained from the board's office or electronically from the board's Internet Web page.

3.1(1) Application expiration. On the examination application due date, the examination application is considered current if it has been one year or less since it was signed and notarized. A comity application expires one year from the date that it was signed and notarized.

3.1(2) Branch licensure. A list of engineering branches in which licensure is granted can be obtained from the board's office. Branches conform to those branches generally included in collegiate curricula. An applicant for licensure in Iowa shall be licensed first in the branch or branches indicated by the applicant's education and experience. A minimum of 50 percent of the required practical experience in which the individual is to be examined shall have been in that same branch of engineering.

3.1(3) Academic transcripts.

a. United States institutions. Completion of post-high school education shall be evidenced by the board's receipt of an applicant's transcripts directly from the office of the registrar of each institution attended.

b. Institutions outside the United States. Transcripts from institutions located outside the boundaries of the United States of America shall be sent directly from the institution to an evaluation service and shall be evaluated for authenticity and substantial equivalency with Accreditation Board for Engineering and Technology, Inc. (ABET) or Engineering Accreditation Commission (EAC) accredited engineering programs. To be readily acceptable, such evaluations shall be from the National Council of Examiners for Engineering and Surveying (NCEES). However, the board may accept evaluations from other recognized foreign credential evaluators satisfactory to the board. The expense of the evaluation is the responsibility of the applicant. Each evaluation shall be sent directly to the board from the evaluation service and shall include a copy of the transcript in the form sent to the evaluation service directly from the educational institution. Each evaluation must address both whether the transcript is authentic and whether the engineering program is equivalent to those accredited by ABET or EAC.

[ARC 9462B, IAB 4/20/11, effective 5/25/11]

193C—3.2(542B) Examination application components and due dates.

3.2(1) Fundamentals of Engineering examination application components and due dates. Applications for the Fundamentals of Engineering examination are submitted directly to the examination service selected by the board to administer the examinations and must be received on or before September 1 of each year for the examination given in the fall and on or before March 1 of each year for the examination given in the spring. Applications from the following applicants are submitted on forms provided by the examination service: any applicant who has an ABET/EAC or Canadian Engineering Accreditation Board (CEAB) accredited engineering degree; any applicant who is enrolled as a senior student in an ABET/EAC or CEAB accredited engineering curriculum; or any applicant who has a master's degree in engineering from an institution in the United States with an accredited bachelor's degree in the same curriculum. Applicants who do not meet the criteria above must submit an application for approval to the board on forms provided by the board. The components of this application include: the completed, notarized application form; references; and transcripts.

3.2(2) Fundamentals of Land Surveying examination application components and due dates. The components of this application include: the completed, notarized application form; references pursuant to 193C—paragraph 5.1(5)“b”; and transcripts. Fundamentals of Land Surveying examination applications require a detailed review and must, therefore, be submitted to the board office, postmarked on or before July 15 of each year for the examination given in the fall and on or before January 15 of each year for the examination given in the spring.

3.2(3) Principles and Practice examination application components and due dates. Principles and Practice of Engineering and Principles and Practice of Land Surveying examination applications require

a detailed review and must, therefore, be submitted to the board office, postmarked on or before July 15 of each year for the examination given in the fall and on or before January 15 of each year for the examination given in the spring. The Principles and Practice examination application packet, including the following components, must be postmarked on or before the deadline date: (1) the completed, notarized and signed application form; (2) the required number of references; (3) the project statement; and (4) the ethics questionnaire. In addition, a complete application file must include verification of examination records and transcripts. Examination applications will not be reviewed by the board until the application file is complete. Since the verification of examination records must be sent directly from the jurisdiction where the applicant took the Fundamentals of Engineering examination, the applicant should contact the other jurisdiction well in advance of the deadline for submittal of the application to request this verification in order to ensure that the verification is received by the board no later than July 25 for the fall examination or by January 25 for the spring examination. For transcripts, the applicant should contact the university well in advance of the deadline for submittal of the application to ensure that the transcripts are received no later than July 25 for the fall examination or by January 25 for the spring examination. Examination application files that are not complete by January 25 will not be reviewed for the spring examination. Likewise, examination applications that are not complete by July 25 will not be reviewed for the fall examination.

[ARC 7754B, IAB 5/6/09, effective 6/10/09]

193C—3.3(542B) Comity applications.

3.3(1) The components of a comity application include: the completed, notarized application form; the ethics questionnaire; references; transcripts; and verification of examinations, as appropriate. Comity applicants may submit the NCEES record in lieu of providing references, verifications, transcripts, and employment history. Since the verification of examination records must, in most cases, be sent directly from the jurisdiction where the applicant took the Fundamentals of Engineering and Principles and Practice Engineering examinations, the applicant should contact the other jurisdiction in advance of submitting the application to request this verification and make every effort to have the verification sent to the board at the time that the application is submitted. Likewise, for transcripts the applicant should contact the university in advance of submitting the application to make every effort to have the transcripts transmitted to the board at the time that the application is submitted.

3.3(2) Comity applications will be reviewed as they are completed. Comity applications will not be reviewed until all components have been received.

3.3(3) Comity applicants will be notified in writing via regular mail or E-mail regarding the results of the review of their applications.

3.3(4) Temporary permits. The board does not issue temporary permits. Based upon review by a board member, temporary permits were previously issued to applicants whose applications met all requirements and who were expected to qualify for approval by the full board at the next regularly scheduled board meeting. Since applications that meet these criteria are now routinely processed as they are completed and reviewed, temporary permits are no longer necessary.

[ARC 7754B, IAB 5/6/09, effective 6/10/09]

193C—3.4(542B) Renewal applications.

3.4(1) *Expiration dates.* Certificates of licensure expire biennially on December 31. Certificates that were initially issued in even-numbered years expire in odd-numbered years and certificates that were initially issued in odd-numbered years expire in even-numbered years. In order to maintain authorization to practice engineering or land surveying in Iowa, licensees are required to renew their certificates of licensure on or prior to the expiration date. A licensee who fails to renew prior to the date the certificate expires shall not be authorized to practice in Iowa unless the certificate is reinstated as provided in these rules. However, the board will accept an otherwise sufficient renewal application which is untimely if the board receives the application and late fee within 30 days of the date of expiration.

3.4(2) *Renewal notification.* The board typically mails a renewal notification to a licensee's last-known address at least one month prior to the license expiration date. Neither the board's failure to mail a renewal notification nor the licensee's failure to receive a renewal notification shall affect in any

way the licensee's duty to timely renew if the licensee intends to continue practicing in Iowa. Licensees need to contact the board office if they do not receive a renewal notification prior to the expiration date.

3.4(3) *Renewal process.* Upon receipt of a timely and sufficient renewal application, with the proper fee, the board's executive secretary shall issue a new license reflecting the next expiration date, unless grounds exist for denial of the application.

3.4(4) *Notification of expiration.* The board shall notify licensees whose certificates of licensure have expired. This notification may be provided through publication in the division's newsletter. The failure of the board to provide this courtesy notification, or the failure of the licensee to receive the courtesy notification, shall not extend the date of expiration.

3.4(5) *Sanction for practicing after license expiration.* A licensee who continues to practice in Iowa after the license has expired shall be subject to disciplinary action. Such unauthorized activity may also provide grounds to deny a licensee's application to reinstate.

3.4(6) *Timely and sufficient renewal application.* Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application shall be:

a. Received by the board in paper or electronic form, or postmarked with a nonmetered United States Postal Service postmark on or before the expiration date of the certificate;

b. Fully completed; and

c. Accompanied by the proper fee. The fee shall be deemed improper if, for instance, the amount is incorrect, the fee was not included with the application, the credit card number provided by the applicant is incorrect, the date of expiration of a credit card is left off the application or is incorrect, the attempted credit card transaction is rejected, or the applicant's check is returned for insufficient funds.

3.4(7) *Responsibility for accuracy of renewal application.* The licensee is responsible for verifying the accuracy of the information submitted on the renewal application regardless of how the application is submitted or by whom it is submitted. For instance, if the office manager of a licensee's firm submits an application for renewal on behalf of the licensee and that information is incorrect, the licensee will be held responsible for the information and may be subject to disciplinary action.

3.4(8) *Denial of renewal application.* If the board, upon receipt of a timely, complete and sufficient application to renew a certificate of licensure, accompanied by the proper fee, denies the application, the executive secretary shall send written notice to the applicant by restricted, certified mail, return receipt requested, identifying the basis for denial. Grounds may exist to deny an application to renew a license if, for instance, the licensee has failed to satisfy the continuing education required as a condition for licensure. If the basis for the denial is a pending disciplinary action or a disciplinary investigation which is reasonably expected to culminate in a formal disciplinary action, the board shall utilize the procedures applicable to disciplinary actions, including the initiation of a contested case. If the basis for denial is not related to a pending or imminent disciplinary action, the applicant may contest the board's decision as provided in 193—7.40(546,272C).

3.4(9) *Continuing education requirement.* A licensee who does not satisfy the continuing education requirements for licensure renewal will be denied renewal of licensure in accordance with subrule 3.4(8).

3.4(10) *Consent order option.* When a licensee appears to be in violation of mandatory continuing education requirements of 193C IAC 7, the board may, in lieu of proceeding to a contested case hearing on the denial of renewal as provided in uniform division rule 193 IAC 7.40(546,272C), offer the licensee the opportunity to sign a consent order. While the terms of a consent order will be tailored to the specific circumstances at issue, the consent order will typically impose a penalty between \$50 and \$250, depending on the severity of the violation, and establish deadlines for compliance, and the consent order may impose additional educational requirements upon the licensee. A licensee is free to accept or reject the offer. If the offer of settlement is accepted, the licensee will be issued a renewed certificate of licensure and, if the terms of the consent order are not complied with, will be subject to disciplinary action. If the offer of settlement is rejected, the matter will be set for hearing, if timely requested by the applicant pursuant to uniform division rule 193 IAC 7.40(546,272C).

3.4(11) *Inactive status.* Licensees who are not engaged in engineering or land surveying practices that require licensure in Iowa may be granted inactive status. No inactive licensee may practice in Iowa unless otherwise exempted in Iowa Code chapter 542B.

193C—3.5(542B) Reinstatement of licensure.

3.5(1) To reinstate a license that has lapsed for one year or more, the applicant for reinstatement must pay the fee required by 193C IAC 2.1(542B) and must satisfy one of the following requirements:

a. Provide documentation of 45 professional development hours achieved within the current and previous biennium (dual licensees must provide documentation of 30 professional development hours for each profession); or

b. Successfully complete the principles and practice examination within one year immediately prior to application for reinstatement; or

c. For an applicant for reinstatement who is an out-of-state resident, submit a statement from the resident state's licensing board as documented evidence of compliance with the resident state's mandatory continuing education requirement during the period that the licensee's Iowa license was lapsed. The statement shall bear the seal of the licensing board. An applicant for reinstatement whose resident state has no mandatory continuing education requirement shall comply with the documented evidence requirement as outlined in this subrule and at 193C IAC 7.8(2).

3.5(2) To reinstate a license that has lapsed for less than one year, the applicant for reinstatement must pay the fee required by 193C IAC 2.1(542B) and must satisfy one of the following requirements:

a. Provide documentation of 30 professional development hours achieved within the current and previous biennium (dual licensees must provide documentation of 20 professional development hours for each profession); or

b. Successfully complete the principles and practice examination within one year immediately prior to application for reinstatement; or

c. For an applicant for reinstatement who is an out-of-state resident, submit a statement from the resident state's licensing board as documented evidence of compliance with the resident state's mandatory continuing education requirement during the period that the licensee's Iowa license was lapsed. The statement shall bear the seal of the licensing board. An applicant for reinstatement whose resident state has no mandatory continuing education requirement shall comply with the documented evidence requirement as outlined in this subrule and at 193C IAC 7.8(2).

3.5(3) A lapsed license may not be reinstated to inactive status.

3.5(4) To reinstate from inactive status to active status, the applicant for reinstatement must pay the fee required by 193C IAC 2.1(542B) and must provide documentation of 45 professional development hours achieved within the current and previous biennium (dual licensees must provide documentation of 30 professional development hours for each profession).

These rules are intended to implement Iowa Code sections 542B.2, 542B.6, 542B.13, 542B.14, 542B.15, 542B.20, 542B.30, 272C.2 and 272C.3.

[Filed 10/24/01, Notice 8/8/01—published 11/14/01, effective 1/1/02]

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CHAPTER 19
REQUIREMENTS FOR MANDATORY ERRORS AND OMISSIONS INSURANCE

[Prior to 9/4/02, see 193E—Ch 6]

193E—19.1(543B) Insurance definitions.

“Aggregate limit” is a provision in an insurance contract limiting the maximum liability of an insurer for a series of losses in a given time period such as the policy term.

“Claims-made” means policies written under a claims-made basis will cover claims made (reported or filed) during the year the policy is in force for incidents which occur that year or during any previous period the policyholder was insured under the claims-made contract. This form of coverage is in contrast to the occurrence policy which covers today’s incident regardless of when a claim is filed even if it is one or more years later.

“Extended reporting period” is a designated period of time after a claims-made policy has expired during which a claim may be made and coverage triggered as if the claim had been made during the policy period.

“Licensee” is any active individual broker, broker associate, or salesperson; any partnership; or any corporation.

“Per claim limit” means the maximum limit payable, per licensee, for damages arising out of the same error, omission, or wrongful act.

“Prior acts coverage” applies to policies on a claims-made versus occurrence basis. Prior acts coverage responds to claims which are made during a current policy period, but the act or acts causing the claim or injuries for which the claim is made occurred prior to the inception of the current policy period.

“Proof of coverage” means a copy of the actual policy of insurance, a certificate of insurance or a binder of insurance.

“Retroactive date” is a provision found in many claims-made policies. The policy will not cover claims for injuries or damages that occurred prior to the retroactive date even if the claim is first made during the policy period.

“Umbrella type coverage” means a policy that provides insurance coverage for the broker or firm and all licensees assigned.

193E—19.2(543B) Insurance requirement—general. The group coverage insurance policy selected by the commission must be approved by the Iowa insurance division. As a condition of licensure under Iowa Code chapter 543B, all active real estate licensees shall submit evidence of compliance with the mandatory errors and omissions insurance requirement when required.

19.2(1) Who shall submit plan of coverage. The following persons must submit proof of insurance when required or when requested:

- a. Any active individual broker, broker associate, or salesperson.
- b. Any active partnership.
- c. Any active corporation.

19.2(2) Inactive status. Individuals whose licenses are on inactive status as defined in Iowa Code section 543B.5(12) are not required to carry errors and omissions insurance.

19.2(3) Territory. All resident Iowa licensees shall be covered for activities contemplated under Iowa Code chapter 543B both in and out of the state of Iowa. Nonresident licensees participating under the state plan shall not be covered both in and out of the state of Iowa unless the state plan selected by the commission will cover participating nonresidents when involved in real estate activities in the nonresident state.

19.2(4) Insurance form. Licensees may obtain errors and omissions coverage through the insurance carrier selected by the commission to provide the group policy coverage. The following are minimum requirements of the group policy to be issued to the Iowa real estate commission including, as named insureds, all licensees who have paid the required premium:

a. All activities contemplated under Iowa Code chapter 543B must be included as covered activities;

b. A per claim limit shall be not less than \$100,000;

c. An annual aggregate limit shall be not less than \$100,000;

d. Limits are to apply per licensee, per claim;

e. Defense costs are to be payable in addition to damages;

f. The contract of insurance shall pay, on behalf of the insured person(s), liabilities owed.

19.2(5) Contract period. The contract between the insurance carrier or program manager and the commission may be written for a one- to three-year period with the option to renew or renegotiate each year thereafter. The commission reserves the right to terminate the contract after written notice to the carrier at least 120 days prior to the end of any policy term and place the contract out for bid.

a. Policy periods shall be not less than 12-month policy terms.

b. The policy shall provide full and complete prior acts coverage.

(1) If the licensee purchased full prior acts coverage on or after July 1, 1991, that licensee shall continue to be guaranteed full prior acts coverage if insurance carriers are changed in the future.

(2) The retroactive date of the master policy shall never be later than July 1, 1991, for those that can provide proof of continuous coverage to that date.

(3) The retroactive date for each licensee shall be individually determined by the inception date of coverage and proof of continuous coverage to that date.

(4) The retroactive date for any new licensee who first obtains a license after July 1, 1991, shall be individually determined by the effective date of the license, the inception date of coverage, and proof of continuous coverage to that date.

19.2(6) Any licensee insured in the state selected program whose license becomes inactive will not be charged an additional premium if the license is reinstated during the policy period.

19.2(7) Any licenses issued at other than renewal and insured by the state selected program shall be subject to a pro-rata premium.

193E—19.3(543B) Other coverage. Licensees are not required to purchase insurance coverage through the group policy selected by the commission and may obtain errors and omissions coverage independently if the coverage contained in the policy complies with the following minimum requirements:

19.3(1) For active individual licensees, all provisions of Iowa Code section 543B.47 apply.

If the other coverage is an individual policy, it shall be each licensee's responsibility to provide proof of independently carried insurance coverage to the Iowa real estate commission when required.

19.3(2) For all active partnerships and corporations, otherwise known as firms, all provisions of Iowa Code section 543B.47 apply.

a. If the other coverage is an individual policy covering the firm, it shall be the designated broker's responsibility to provide proof of the firm's independently carried insurance coverage to the Iowa real estate commission when required.

b. If the other coverage is an umbrella type policy covering the firm and all licensees assigned that perform real estate activities, it shall be the responsibility of the designated broker of the firm to provide a list of licensees assigned to the firm that are covered under the firm's insurance policy to the Iowa real estate commission when required.

19.3(3) For sole-proprietor single license brokers, all provisions of Iowa Code section 543B.47 apply.

a. If the broker's other coverage is an individual policy, it shall be each licensee's responsibility to provide proof of the independently carried insurance coverage to the Iowa real estate commission when required, as provided in 19.3(1).

b. If the other coverage is an umbrella type policy covering the broker and all licensees assigned that perform real estate activities, it shall be the responsibility of the broker to provide a list of licensees assigned to the broker that are covered under the broker's insurance policy to the Iowa real estate commission when required.

19.3(4) For independently carried individual type coverage, the following minimum requirements shall apply:

a. All activities contemplated under Iowa Code chapter 543B must be included as covered activities.

b. A per claim limit shall be not less than \$100,000.

c. The maximum deductible for an individual policy for damages and defense, each licensee, and each claim shall not be more than the deductible of the commission group policy for the current policy term.

19.3(5) For firms and sole-proprietor brokerages with independently carried firm umbrella type coverage, the following minimum requirements shall apply:

a. All activities contemplated under Iowa Code chapter 543B must be included as covered activities.

b. A per claim limit shall be not less than \$100,000.

c. An aggregate limit shall be:

(1) Not less than \$250,000 for a broker or firm with 2 through 10 licensees;

(2) Not less than \$500,000 for a broker or firm with 11 through 40 licensees;

(3) Not less than \$1,000,000 for a broker or firm with 41 or more licensees.

d. There is no maximum deductible limit for firm umbrella type coverage policy.

e. If a firm size change or a sole-proprietor brokerage size change results in a higher aggregate minimum requirement, that firm or broker shall correct the deficiency within one year, or the next renewal term of the insurance policy, whichever comes first.

19.3(6) To comply with the provisions of the Iowa errors and omissions law, if other independently carried insurance is provided, as proof of errors and omissions coverage for individual or firm umbrella type coverage, the other insurance carrier shall agree to either a noncancelable policy, or provide a letter of commitment to notify the Iowa real estate commission 30 days prior to the intention to cancel the policy.

19.3(7) Whenever commission requirements, coverage, or limits change, the commission shall provide a reasonable transition period to allow the licensee or firm with other coverage the opportunity to change carriers or coverage to comply with all requirements and limits, providing the present policy was in effect and in compliance with all prior requirements. The licensee or firm shall correct the deficiency within one year, or not later than the next renewal term of the insurance policy, whichever comes first.

19.3(8) It shall be the responsibility of each individual licensee to notify the commission when changing insurance status, coverage, or provider when required or when requested.

19.3(9) It shall be the responsibility of the designated broker of the firm to notify the commission when changing insurance status, coverage, or provider when required or when requested.

19.3(10) Self-insurance does not comply with the provisions of the Iowa errors and omissions insurance law.

193E—19.4(543B) Administrative requirements—general.

19.4(1) It is the responsibility of the insurance carrier or program manager to obtain approval from the Iowa division of insurance for the group policy before inception of the program or policy period.

19.4(2) It is the responsibility of the insurance carrier or program manager to handle administrative duties relative to operation of the program selected by the commission, including billing and premium collection, toll-free access for questions, and claim processing and general informational mailings.

19.4(3) It is the responsibility of the insurance carrier or program manager to send a billing notice to each licensee.

19.4(4) It is the responsibility of the insurance carrier or program manager to collect all premiums due and verify proper payment.

A schedule of licensees who have paid the proper premium and who have coverage in force shall be provided electronically to the commission at agreed time intervals.

19.4(5) It is the responsibility of the insurance carrier or program manager to issue individual certificates to each licensee and a master policy to the commission.

19.4(6) It is the responsibility of the insurance carrier or program manager to market its program and to develop and distribute informational brochures about the coverages provided, services available and requirements of Iowa Code section 543B.47.

a. The content of any brochures or other literature provided is the responsibility of the insurance carrier or program manager.

b. Advertising materials may be reviewed by the executive officer for the commission or appropriate staff person for content only and not for a legal determination of compliance with Iowa law or division of insurance requirements.

19.4(7) It is the responsibility of the insurance carrier or program manager to provide educational seminars in the state of Iowa at the request of the commission and subject to terms and conditions agreeable to each party involved.

193E—19.5(543B) Commission responsibilities. The commission shall provide the insurance carrier or program manager an electronic schedule of all active licensees approximately three months in advance of inception (or renewal), or as otherwise agreed upon, which the insurance carrier or program manager may use to issue billing notices.

19.5(1) The insurance carrier or program manager shall provide the commission with a schedule of insured licensees. The commission will be responsible for comparing this schedule against its own records to determine which licensees elected not to participate in the state program and those that have failed to furnish the commission with acceptable proof of insurance necessary for continued licensure.

19.5(2) It shall be the responsibility of the commission to review proof of other insurance received from licensees not participating in the state program and to confirm that the other insurance meets the minimum requirements of these rules.

19.5(3) The commission may require that an approved standard form be used to submit proof of other insurance coverage for review.

193E—19.6(543B) Compliance.

19.6(1) The commission shall require receipt of proof of errors and omissions insurance from new licensees before the license is issued.

19.6(2) The commission shall require receipt of proof of errors and omissions insurance from the applicant before reinstating an expired license.

19.6(3) The commission shall require receipt of proof of errors and omissions insurance before reactivating an inactive status license to active status if the license has been inactive for more than 20 days.

19.6(4) Applicants for license renewal shall attest and certify that they have current errors and omissions insurance in effect that meets Iowa insurance requirements.

a. The commission will verify by random audit or on a test basis the insurance compliance attested to by the licensee.

b. Licensees participating in the state group program may not be audited if commission records indicate the insurance carrier or program manager has submitted current proof of coverage.

c. Licensees with other insurance coverage may not be audited if commission records indicate the current proof of coverage has been submitted.

d. The commission may random audit by any factor as will provide a reasonable sampling given the volume, purpose and scope of audit.

e. The commission may random audit as the result of any complaint filed with the commission whether or not adequate insurance coverage was questioned in the complaint.

f. The commission may audit compliance with insurance coverage at any time the commission has reasonable cause to question a licensee's compliance.

19.6(5) A licensee is required to carry insurance on an uninterrupted basis and may not avoid discipline simply by acquiring insurance after receipt of an audit notice.

19.6(6) Failure of a licensee to carry adequate insurance coverage or to submit proof of insurance to the commission within 20 calendar days of the commission's request as required shall be prima facie evidence of a violation of Iowa Code sections 543B.15(5), 543B.47(1), and 543B.47(6) and is grounds for the denial of an application for licensure, the denial of an application to renew a license, or the suspension or revocation of a license.

19.6(7) Submitting false documentation of insurance coverage, or falsely claiming to have or attesting to having insurance coverage, shall be prima facie evidence of violation of Iowa Code sections 543B.29(1) and 543B.34(1).

19.6(8) Failure to provide required proof of insurability within 30 days of written notice by the commission shall result in the placement of the license on inactive status. A license that has been placed on inactive status pursuant to this provision shall not be reactivated until satisfactory evidence has been provided verifying that coverage is current and in full force and effect.

[ARC 9458B, IAB 4/20/11, effective 5/25/11]

193E—19.7(543B) Records and retention. It is the responsibility of the licensee to maintain records which support the validity of the insurance. Documentation shall be retained by the licensee for a period of three years after the license renewal date or the anniversary of the license renewal date.

These rules are intended to implement Iowa Code chapters 17A, 272C and 543B.

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EDUCATION DEPARTMENT[281]

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 (Replacement pages for 9/7/88 published in 9/21/88 IAC)

TITLE I
*GENERAL INFORMATION—
 DEPARTMENT OPERATIONS*

CHAPTER 1
 ORGANIZATION AND OPERATION

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CHAPTER 36
EXTRACURRICULAR INTERSCHOLASTIC COMPETITION
[Prior to 9/7/88, see Public Instruction Department[670] Ch 9]

281—36.1(280) Definitions Whenever the following terms are used, they shall refer to the following definitions:

“All-star” means a secondary student from a high school interscholastic athletic team whose outstanding performance is the basis for the student’s selection to compete individually in an all-star contest or on an all-star high school team to compete with other all-stars from several other high school teams against another all-star team in an all-star contest. An “all-star” shall not include a twelfth grade student whose interscholastic athletic season for the sport in question has concluded.

NOTE: Bylaw 14.6 of the National Collegiate Athletic Association (NCAA) (as revised 7/30/10) states that a “student-athlete shall be denied the first year of intercollegiate athletics competition if, following completion of high-school eligibility in the student-athlete’s sport and prior to the student-athlete’s high-school graduation, the student-athlete competes in more than two all-star football contests or two all-star basketball contests.”

“All-star contest” means an event for which admission is charged and at which all-stars compete during the school year against other all-stars, either individually or as all-star teams. “All-star contests” shall not include noninvitational events for which students audition or try out or the auditions or try outs themselves.

“Associate member school” means a nonaccredited nonpublic school that has been granted associate member status by any corporation, association, or organization registered with the state department of education pursuant to Iowa Code section 280.13, upon approval by the department based upon proof of compliance with:

1. Iowa Code section 279.19B, and rules adopted by the department of education related to the qualifications of the affected teaching staff, and
2. The student eligibility rules of this chapter.

Associate membership is subject to the requirements, dues, or other obligations established by the organization for which associate membership is sought.

“Coach” means an individual, with coaching endorsement or authorization as required by Iowa law, employed by a school district under the provisions of an extracurricular athletic contract or employed by a nonpublic school in a position responsible for an extracurricular athletic activity. “Coach” also includes an individual who instructs, diagnoses, prescribes, evaluates, assists, or directs student learning of an interscholastic athletic endeavor on a voluntary basis on behalf of a school or school district.

“Compete” means participating in an interscholastic contest or competition and includes dressing in full team uniform for the interscholastic contest or competition as well as participating in pre-game warm-up exercises with team members. “Compete” does not include any managerial, record-keeping, or other non-competitor functions performed by a student on behalf of a member or associate member school.

“Department” means the state department of education.

“Dropout” means a student who quit school because of extenuating circumstances over which the student had no control or who voluntarily withdrew from school. This does not include a student who has been expelled or one who was doing failing work when the student voluntarily dropped from school.

“Executive board” means the governing body authorized under a constitution or bylaws to establish policy for an organization registered under this chapter.

“Executive officer” means the executive director or secretary of each governing organization.

“Member school,” for purposes of this chapter, means a public school or accredited nonpublic school that has been granted such status by any corporation, association, or organization registered with the state department of education pursuant to Iowa Code section 280.13.

“Parent” means the natural or adoptive parent having actual bona fide custody of a student.

“*Student*” means a person under 20 years of age enrolled in grades 9 through 12. For purposes of these rules, ninth grade begins with the summer immediately following eighth grade. The rules contained herein shall apply uniformly to all students.

“*Superintendent*” means a superintendent of a local school or a duly authorized representative.
[ARC 9475B, IAB 4/20/11, effective 5/25/11]

281—36.2(280) Registered organizations. Organizations registered with the department include the following:

- 36.2(1)** Iowa High School Athletic Association (hereinafter association).
- 36.2(2)** Iowa Girls’ High School Athletic Union (hereinafter union).
- 36.2(3)** Iowa High School Music Association (hereinafter music association).
- 36.2(4)** Iowa High School Speech Association (hereinafter speech association).
- 36.2(5)** Unified Iowa High School Activities Federation (hereinafter federation).

281—36.3(280) Filings by organizations. Each organization shall maintain a current file with the state department of education of the following items:

- 36.3(1)** Constitution and bylaws which must have the approval of the state board of education.
- 36.3(2)** Current membership and associate membership lists.
- 36.3(3)** Organization policies.
- 36.3(4)** Minutes of all meetings of organization boards.
- 36.3(5)** Proposed constitution and bylaw amendments or revisions.
- 36.3(6)** Audit reports.
- 36.3(7)** General bulletins.
- 36.3(8)** Other information pertinent to clarifying organization administration.

281—36.4(280) Executive board. Each organization shall have some representation from school administrators, teachers, and elective school officers on its executive board; provided, however, that the membership shall include the following:

36.4(1) School board member. One member who shall be a member of a school board in Iowa, appointed by the Iowa association of school boards to represent the lay public.

36.4(2) Activity member. One member, who is either a coach, sponsor or director, of an activity sponsored by the organization to which the member is elected and who works directly with the students or the program: This member is to be elected by ballot of the member schools, the vote to be cast by the school’s designated representative of the organization involved.

36.4(3) Organization elections. The election procedure for each organization shall be conducted as provided by the organization’s constitution. All criteria for protecting the voter’s anonymity and ensuring adequate notice of elections shall be maintained in the election procedures. In addition, there shall be one representative designated by the department director present at the counting of all ballots. That representative shall also validate election results.

281—36.5(280) Federation membership. The federation, in addition to conforming to other requirements in this section, shall have in its membership the executive board of the association, union, music association, speech association, and the school administrators of Iowa.

281—36.6(280) Salaries. No remuneration, salary, or remittance shall be made to any member of an executive board, representative council or advisory committee, of an organization for the member’s service.

281—36.7(280) Expenses. Travel and actual expenses of executive board members, representative council members, advisory committee members, and officers shall be paid from organizational funds only when on official business for the organization. Actual expenses shall be paid for travel for transportation outside the state, along with necessary and reasonable expenses which shall be itemized.

Itemized accounting of the travel and business expenses of employees shall be furnished to the department in an annual report on a form prescribed by the department.

281—36.8(280) Financial report. Full and detailed reports of all receipts and expenditures shall be filed annually with the department of education.

281—36.9(280) Bond. The executive board of each activity organization shall purchase a blanket fidelity bond from a corporate surety approved by it, conditioned upon the faithful performance of the duties of the executive officer, the members of the executive board, and all other employees of the activity organization. Such blanket bond shall be in a penal amount set by the executive board and shall be the sum of 50 percent of the largest amount of moneys on hand in any 30-day period during the preceding fiscal year, and 20 percent of the net valuation of all assets of the activity organization as of the close of the last fiscal year, but such bond shall in no case be in an amount less than \$10,000.

281—36.10(280) Audit. The financial condition and transaction of all organizations shall be examined once each year, or more often if directed by the director of education, by either a certified public accountant chosen by the organization or by a committee chosen by the organization and approved by the director of education.

281—36.11(280) Examinations by auditors. Auditors shall have the right while making the examination to examine all organization papers, books, records, tickets, and documents of any of the officers and employees of the organizations, and shall have the right in the presence of the custodian or deputy, to have access to the cash drawers and cash in the official custody of the officer and to the records of any depository which has funds of the organization in its custody.

281—36.12(280) Access to records. Upon request, organizations shall make available to the state department of education or its delegated representative all records, data, written policies, books, accounts, and other materials relating to any or all aspects of their operations.

281—36.13(280) Appearance before state board. At the request of the state board of education or its executive officer, members of the governing boards and employees of the organizations shall appear before and give full accounting and details on the aforesaid matters to the state board of education.

281—36.14(280) Interscholastic athletics. In addition to the requirements of rule 36.15(280), organizations shall prescribe and implement the rules described below for participants in interscholastic athletic competition.

36.14(1) Physical examination. Every year each student shall present to the student's superintendent a certificate signed by a licensed physician and surgeon, osteopathic physician and surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner, to the effect that the student has been examined and may safely engage in athletic competition.

Each doctor of chiropractic licensed as of July 1, 1974, shall affirm on each certificate of physical examination completed that the affidavit required by Iowa Code section 151.8 is on file with the Iowa board of chiropractic.

The certificate of physical examination is valid for the purpose of this rule for one calendar year. A grace period not to exceed 30 calendar days is allowed for expired physical certifications.

36.14(2) Sportsmanship. It is the clear obligation of member and associate member schools to ensure that their contestants, coaches, and spectators in all interscholastic competitions practice the highest principles of sportsmanship, conduct, and ethics of competition. The governing organization shall have authority to penalize any member school, associate member school, contestant, or coach in violation of this obligation.

36.14(3) Awards.

a. Awards from a secondary school or registered organization. For participation in an interscholastic athletic contest or program, a student will be permitted to receive from the student's

school, another secondary school, a registered organization, or the host of an event sanctioned by a registered organization an award whose value cannot exceed \$50.

b. Awards for participation in school programs from an individual or organization other than a secondary school or registered organization. No student shall receive any award from an individual or outside organization for high school participation while enrolled in high school, except that nothing in this subrule shall preclude the giving of a complimentary dinner by local individuals, organizations, or groups, with approval of the superintendent, to members of the local high school athletic squad. No student shall accept any trip or excursion of any kind by any individual, organization, or group outside the student's own school or the governing organization, with the exception of bona fide recruiting trips that meet NCAA requirements. Nothing in this subrule shall preclude or prevent the awarding and the acceptance of an inexpensive, unmounted, unframed paper certificate of recognition as an award, or an inexpensive table favor which is given to everyone attending a banquet.

c. Awards for participation in nonschool programs. If a student participates in an outside school activity, the student may receive any award provided that the award does not violate the amateur award rule of the amateur sanctioning body for that sport. In the absence of an applicable amateur award rule, the student shall not receive any award the value of which exceeds \$50.

d. Absolute prohibition on cash. At no time may any student accept an award of cash.

e. Compliance. The superintendent or designee shall be held responsible for compliance with this subrule. Questions or interpretation regarding medals or awards shall be referred to the executive board.

36.14(4) Interstate competition. Every student participating in interstate athletic competition on behalf of the student's school must meet the eligibility rules.

36.14(5) Competition seasons. The length of training periods and competition seasons shall be determined solely by the governing organization.

36.14(6) Tournaments. The number and type of state tournaments for the various sports shall be determined by the organization. In scheduling and conducting these tournaments, the organization shall have the final authority for determining the tournament eligibility of all participants. Organization bylaws shall provide for a timely method of seeking an internal review of initial decisions regarding tournament eligibility.

36.14(7) Ineligible player competition. Member or associate member schools that permit or allow a student to compete in an interscholastic competition in violation of the eligibility rules or that permit or allow a student who has been suspended to so compete shall be subject to penalties imposed by the executive board. The penalties may include, but are not limited to, the following: forfeiture of contests or events or both, involving any ineligible student(s); adjustment or relinquishment of conference/district/tournament standings; and return of team awards or individual awards or both.

If a student who has been declared ineligible or who has been suspended is permitted to compete in an interscholastic competition because of a current restraining order or injunction against the school, registered organization, or department of education, and if such restraining order or injunction subsequently is voluntarily vacated, stayed, reversed, or finally determined by the courts not to justify injunctive relief, the penalties listed above may be imposed.

This rule is intended to implement Iowa Code section 280.13.

[ARC 9475B, IAB 4/20/11, effective 5/25/11; ARC 9477B, IAB 4/20/11, effective 5/25/11]

281—36.15(280) Eligibility requirements.

36.15(1) Local eligibility and student conduct rules. Local boards of education may impose additional eligibility requirements not in conflict with these rules. Nothing herein shall be construed to prevent a local school board from declaring a student ineligible to participate in interscholastic competition by reason of the student's violation of rules adopted by the school pursuant to Iowa Code sections 279.8 and 279.9. A member or associate member school shall not allow any student, including any transfer student, to compete until such time as the school has reasonably reliable proof that the student is eligible to compete for the member or associate member school under these rules.

36.15(2) Scholarship rules.

a. All contestants must be enrolled and in good standing in a school that is a member or associate member in good standing of the organization sponsoring the event.

b. All contestants must be under 20 years of age.

c. All contestants shall be enrolled students of the school in good standing. They shall receive credit in at least four subjects, each of one period or “hour” or the equivalent thereof, at all times. To qualify under this rule, a “subject” must meet the requirements of 281—Chapter 12. Coursework taken from a postsecondary institution and for which a school district or accredited nonpublic school grants academic credit toward high school graduation shall be used in determining eligibility. No student shall be denied eligibility if the student’s school program deviates from the traditional two-semester school year.

(1) Each contestant shall be passing all coursework for which credit is given and shall be making adequate progress toward graduation requirements at the end of each grading period. Grading period, graduation requirements, and any interim periods of ineligibility are determined by local policy. For purposes of this subrule, “grading period” shall mean the period of time at the end of which a student in grades 9 through 12 receives a final grade and course credit is awarded for passing grades.

(2) If at the end of any grading period a contestant is given a failing grade in any course for which credit is awarded, the contestant is ineligible to dress for and compete in the next occurring interscholastic athletic contests and competitions in which the contestant is a contestant for 30 consecutive calendar days.

d. A student with a disability who has an individualized education program shall not be denied eligibility on the basis of scholarship if the student is making adequate progress, as determined by school officials, towards the goals and objectives on the student’s individualized education program.

e. A student who meets all other qualifications may be eligible to participate in interscholastic athletics for a maximum of eight consecutive semesters upon entering the ninth grade for the first time. However, a student who engages in athletics during the summer following eighth grade is also eligible to compete during the summer following twelfth grade. Extenuating circumstances, such as health, may be the basis for an appeal to the executive board which may extend the eligibility of a student when the executive board finds that the interests of the student and interscholastic athletics will be benefited.

f. All member schools shall provide appropriate interventions and necessary academic supports for students who fail or who are at risk to fail, and shall report to the department regarding those interventions on the comprehensive school improvement plan.

g. A student is academically eligible upon entering the ninth grade.

h. A student is not eligible to participate in an interscholastic sport if the student has, in that same sport, participated in a contest with or against, or trained with, a National Collegiate Athletic Association (NCAA), National Junior College Athletic Association (NJCAA), National Association of Intercollegiate Athletics (NAIA), or other collegiate governing organization’s sanctioned team. A student may not participate with or against high school graduates if the graduates represent a collegiate institution or if the event is sanctioned or sponsored by a collegiate institution. Nothing in this subrule shall preclude a student from participating in a one-time tryout with or against members of a college team with permission from the member school’s administration and the respective collegiate institution’s athletic administration.

i. No student shall be eligible to participate in any given interscholastic sport if the student has engaged in that sport professionally.

j. The local superintendent of schools, with the approval of the local board of education, may give permission to a dropout student to participate in athletics upon return to school if the student is otherwise eligible under these rules.

k. Remediation of a failing grade by way of summer school or other means shall not affect the student’s ineligibility. All failing grades shall be reported to any school to which the student transfers.

36.15(3) General transfer rule. A student who transfers from a school in another state or country or from one member or associate member school to another member or associate member school shall be ineligible to compete in interscholastic athletics for a period of 90 consecutive school days, as defined in rule 281—12.1(256), exclusive of summer enrollment, unless one of the exceptions listed

in paragraph 36.15(3)“a” applies. The period of ineligibility applies only to varsity level contests and competitions. (“Varsity” means the highest level of competition offered by one school or school district against the highest level of competition offered by an opposing school or school district.) In ruling upon the eligibility of transfer students, the executive board shall consider the factors motivating student changes in residency. Unless otherwise provided in these rules, a student intending to establish residency must show that the student is physically present in the district for the purpose of making a home and not solely for school or athletic purposes.

a. Exceptions. The executive officer or executive board shall consider and apply the following exceptions in formally or informally ruling upon the eligibility of a transfer student and may make eligibility contingent upon proof that the student has been in attendance in the new school for at least ten school days:

(1) Upon a contemporaneous change in parental residence, a student is immediately eligible if the student transfers to the new district of residence or to an accredited nonpublic member or associate member school located in the new school district of residence. In addition, if with a contemporaneous change in parental residence, the student had attended an accredited nonpublic member or associate member school immediately prior to the change in parental residence, the student may have immediate eligibility if the student transfers to another accredited nonpublic member or associate member school.

(2) If the student is attending in a school district as a result of a whole-grade sharing agreement between the student’s resident district and the new school district of attendance, the student is immediately eligible.

(3) A student who has attended high school in a district other than where the student’s parent(s) resides, and who subsequently returns to live with the student’s parent(s), becomes immediately eligible in the parent’s resident district.

(4) Pursuant to Iowa Code section 256.46, a student whose residence changes due to any of the following circumstances is immediately eligible provided the student meets all other eligibility requirements in these rules and those set by the school of attendance:

1. Adoption.
2. Placement in foster or shelter care.
3. Participation in a foreign exchange program, as evidenced by a J-1 visa issued by the United States government, unless the student attends the school primarily for athletic purposes.
4. Placement in a juvenile correction facility.
5. Participation in a substance abuse program.
6. Participation in a mental health program.
7. Court decree that the student is a ward of the state or of the court.
8. The child is living with one of the child’s parents as a result of divorce, separation, death, or other change in the child’s parents’ marital relationship, or pursuant to other court-ordered decree or order of custody.

(5) A transfer student who attends in a member or associate member school that is a party to a cooperative student participation agreement, as defined in rule 36.20(280), with the member or associate member school the student previously attended is immediately eligible in the new district to compete in those interscholastic athletic activities covered by the cooperative agreement.

(6) Any student whose parents change district of residence but who remains in the original district without interruption in attendance continues to be eligible in the member or associate member school of attendance.

(7) A special education student whose attendance center changes due to a change in placement agreed to by the district of residence is eligible in either the resident district or the district of attendance, but not both.

(8) In any transfer situation not provided for elsewhere in this chapter, the executive board shall exercise its administrative authority to make any eligibility ruling which it deems to be fair and reasonable. The executive board shall consider the motivating factors for the student transfer. The determination shall be made in writing with the reasons for the determination clearly delineated.

b. In ruling upon the transfer of students who have been emancipated by marriage or have reached the age of majority, the executive board shall consider all circumstances with regard to the transfer to determine if it is principally for school or athletic purposes, in which case participation shall not be approved.

c. A student who participates in the name of a member or associate member school during the summer following eighth grade is ineligible to participate in the name of another member or associate member school in the first 90 consecutive school days of ninth grade unless a change of residence has occurred after the student began participating in the summer.

d. A school district that has more than one high school in its district shall set its own eligibility policies regarding intradistrict transfers.

36.15(4) *Open enrollment transfer rule.* A student in grades 9 through 12 whose transfer of schools had occurred due to a request for open enrollment by the student's parent or guardian is ineligible to compete in interscholastic athletics during the first 90 school days of transfer except that a student may participate immediately if the student is entering grade 9 for the first time and did not participate in an interscholastic athletic competition for another school during the summer immediately following eighth grade. The period of ineligibility applies only to varsity level contests and competitions. ("Varsity" means the highest level of competition offered by one school or school district against the highest level of competition offered by an opposing school or school district.) This period of ineligibility does not apply if the student:

a. Participates in an athletic activity in the receiving district that is not available in the district of residence; or

b. Participates in an athletic activity for which the resident and receiving districts have a cooperative student participation agreement pursuant to rule 36.20(280); or

c. Has paid tuition for one or more years to the receiving school district prior to making application for and being granted open enrollment; or

d. Has attended in the receiving district for one or more years prior to making application for and being granted open enrollment under a sharing or mutual agreement between the resident and receiving districts; or

e. Has been participating in open enrollment and whose parents/guardians move out of their district of residence but exercise either the option of remaining in the original open enrollment district or enrolling in the new district of residence. If the pupil has established athletic eligibility under open enrollment, it is continued despite the parent's or guardian's change in residence; or

f. Has not been participating in open enrollment, but utilizes open enrollment to remain in the original district of residence following a change of residence of the student's parent(s). If the pupil has established athletic eligibility, it is continued despite the parent's or guardian's change in residence; or

g. Obtains open enrollment due to the dissolution and merger of the former district of residence under Iowa Code subsection 256.11(12); or

h. Obtains open enrollment due to the pupil's district of residence entering into a whole-grade sharing agreement on or after July 1, 1990, including the grade in which the pupil would be enrolled at the start of the whole-grade sharing agreement; or

i. Participates in open enrollment and the parent/guardian is an active member of the armed forces and resides in permanent housing on government property provided by a branch of the armed services.

36.15(5) *Eligibility for other enrollment options.*

a. *Shared-time students.* A nonpublic school student who is enrolled only part-time in the public school district of the student's residence under a "shared-time" provision or for driver education is not eligible to compete in interscholastic athletics in the public school district.

b. *Dual enrollment.* A student who receives competent private instruction, not in an accredited nonpublic or public school, may seek dual enrollment in the public school of the student's resident district and is eligible to compete in interscholastic athletic competition in the resident school district provided the student meets the eligibility requirements of these rules and those set by the public school of attendance.

If a student seeking such dual enrollment is enrolled in an associate member school of the Iowa Girls' High School Athletic Union or Iowa High School Athletic Association, the student is eligible for and may participate in interscholastic athletic competition only for the associate member school or a school with which the associate member school is in a cooperative sharing agreement. (Eligibility in such case is governed by 281 IAC 36.1(280).)

Any ineligibility imposed under this chapter shall begin with the first day of participation under dual enrollment. Any period of ineligibility applies only to varsity level contests and competitions. ("Varsity" means the highest level of competition offered by one school or school district against the highest level of competition offered by an opposing school or school district.)

c. Competent private instruction. A student who receives competent private instruction, and is not dual-enrolled in a public school, may participate in and be eligible for interscholastic athletics at an accredited nonpublic school if the student is accepted by that school and the student meets the eligibility requirements of this chapter and those set by the accredited nonpublic school where the student participates. Application shall be made to the accredited nonpublic school on a form provided by the department of education.

If a student seeking such participation is enrolled in an associate member school of the Iowa Girls' High School Athletic Union or Iowa High School Athletic Association, the student is eligible for and may participate in interscholastic athletic competition only for the associate member school or a school with which the associate member school is in a cooperative sharing agreement. (Eligibility in such case is governed by 281 IAC 36.1(280).)

Any ineligibility imposed under this chapter shall begin with the first day of participation with the accredited nonpublic school. Any period of ineligibility applies only to varsity level contests and competitions. ("Varsity" means the highest level of competition offered by one school or school district against the highest level of competition offered by an opposing school or school district.)

36.15(6) *Summer camps and clinics and coaching contacts out of season.*

a. School personnel, whether employed or volunteers, of a member or associate member school shall not coach that school's student athletes during the school year in a sport for which the school personnel are currently under contract or are volunteers, outside the period from the official first day of practice through the finals of tournament play. Provided, however, school personnel may coach a senior student from the coach's school in an all-star contest once the senior student's interscholastic athletic season for that sport has concluded. In addition, volunteer or compensated coaching personnel shall not require students to participate in any activities outside the season of that coach's sport as a condition of participation in the coach's sport during its season.

b. A summer team or individual camp or clinic held at a member or associate member school facility shall not conflict with sports in season. Summertime coaching activities shall not conflict with sports in season.

c. Rescinded IAB 4/20/11, effective 5/25/11.

d. Penalty. A school whose volunteer or compensated coaching personnel violate this rule is ineligible to participate in a governing organization-sponsored event in that sport for one year with the violator(s) coaching.

36.15(7) *Nonschool team participation.* The local school board shall by policy determine whether or not participation in nonschool athletic events during the same season is permitted and provide penalties for students who may be in violation of the board's policy.

This rule is intended to implement Iowa Code sections 256.46, 280.13 and 282.18.

[ARC 9475B, IAB 4/20/11, effective 5/25/11; ARC 9476B, IAB 4/20/11, effective 5/25/11]

281—36.16(280) Executive board review. A student, parent of a minor student, or school contesting the ruling of a student's eligibility based on these rules, other than subrule 36.15(1) or paragraph 36.15(2) "c," "d," "f," or "k," or a school contesting a penalty imposed under paragraph 36.15(6) "b," shall be required to state the basis of the objections in writing, addressed to the executive officer of the board of the governing organization. Upon request of a student, parent of a minor student, or a school, the executive officer shall schedule a hearing before the executive board on or before the next

regularly scheduled meeting of the executive board but not later than 20 calendar days following the receipt of the objections unless a later time is mutually agreeable. The executive board shall give at least 5 business days' written notice of the hearing. The executive board shall consider the evidence presented and issue findings and conclusions in a written decision within 5 business days of the hearing and shall mail a copy to appellant.

[ARC 9475B, IAB 4/20/11, effective 5/25/11]

281—36.17(280) Appeals to director. If the claimant is still dissatisfied, an appeal may be made in writing to the director of education by giving written notice of the appeal to the state director of education with a copy by registered mail to the executive officer of the governing organization. An appeal shall be in the form of an affidavit and shall be filed within 10 business days after the date of mailing of the decision of the governing organization. The director of education shall establish a date for hearing within 20 calendar days of receipt of written notice of appeal by giving at least 5 business days' written notice of hearing to the appellant unless another time is mutually agreeable. The procedures for hearing adopted by the state board of education and found at 281—Chapter 6 shall be applicable, except that the decision of the director is final. Appeals to the executive board and the state director are not contested cases under Iowa Code subsection 17A.2(5).

[ARC 9475B, IAB 4/20/11, effective 5/25/11]

281—36.18(280) Organization policies. The constitution or bylaws of organizations sponsoring contests for participation by member schools shall reflect the following policies:

36.18(1) Expenditure policy. It shall be the expenditure policy of each organization, after payment of costs incurred in 36.6(280) to 36.9(280) and legitimate expenses for housing, equipment and supplies including by agreement with other organizations having a mutual interest in interscholastic activities, to use all receipts to promote and fiscally sponsor those extracurricular interscholastic contests and competitions deemed by it to be most beneficial to all eligible students enrolled in member schools. Organizations with large revenues may provide assistance in staff, space, equipment and the transfer of funds to other organizations whose contests or competitions do not generate sufficient moneys to carry out an adequate program in their areas of service. Each organization shall make an annual payment to the federation to cover the necessary expenditures of the federation. The amount of this payment shall be determined by the federation.

36.18(2) Federation survey. A survey shall be made at least biennially, using a sampling procedure selected by the executive committee of the federation to determine in what extracurricular interscholastic contests or competitions students of member secondary schools would like to participate. The organizations shall put high priority on the findings of the survey in the determination of what interscholastic activities are to be sponsored.

36.18(3) Calendar of events. The federation shall establish yearly in advance a calendar of events for the interscholastic contests and competitions sponsored by the organizations.

36.18(4) Information to local member schools. The federation shall distribute to member schools the yearly calendar of events and other information believed by officers of the federation to be helpful to local school officials in providing a comprehensive program of extracurricular interscholastic contests or competitions.

36.18(5) "All-star" contests. A student enrolled in a member or associate member school will be ineligible for 12 calendar months in the sport in which the violation occurred if the student participates in an all-star contest.

36.18(6) Team participation. Participation in interscholastic contests or competitions shall be by school teams only and not selected individuals, with the exception of individual sports events such as wrestling, track, cross country, golf, tennis, and music and speech activities.

36.18(7) Contests outside Iowa. Out-of-state contest participation by a member school shall be limited to regularly scheduled interscholastic activities.

36.18(8) Promoting interstate contests. No activity organization shall sponsor interstate contests or competition between individuals, teams or groups.

36.18(9) Chaperones. It is the responsibility of all school districts to see that all teams or contestants are properly chaperoned when engaged in interscholastic activities.

36.18(10) Membership. Membership in an organization shall be limited to schools accredited by the department or approved by the department solely for purposes of associate membership in a registered organization.

281—36.19(280) Eligibility in situations of district organization change. Notwithstanding any other provision of this chapter, in the event eligibility of one or more students is jeopardized or in question as a result of actions beyond their control due to pending reorganization of school districts approved by the voters under Iowa Code chapter 275; action of the district boards of directors under Iowa Code section 274.37; or the joint employment of personnel and sharing of facilities under Iowa Code section 280.15 and the result is a complete discontinuance of the high school grades, or discontinuance of the high school grades pursuant to Iowa Code section 282.7, first paragraph, the boards of directors of the school districts involved may, by written agreement, determine the eligibility of students for the time the district of residence does not provide an activity program governed by this chapter. When the respective boards have not provided by written agreement for the eligibility of students whose eligibility is jeopardized or questioned four weeks prior to the normal established time for beginning the activity, students or parents of students involved may request a determination of eligibility from the governing body of the organization involved. All parties directly interested shall be given an opportunity to present their views to the governing board.

A determination of eligibility by the governing board shall be based upon fairness and the best interests of the students.

In the event that one or more parties involved in the request for determination before the governing board are dissatisfied with the decision of the governing board, an appeal may be made by the dissatisfied party to the director of the department under the provisions of 36.17(280). A decision of the director in the matter shall be final.

The above provisions shall apply insofar as applicable to changes of organization entered into between two or more nonpublic schools.

This rule is intended to implement Iowa Code section 280.13.

281—36.20(280) Cooperative student participation. Notwithstanding any other provision of this chapter, in the event a member or associate member school does not directly make participation in an interscholastic activity available to its students, the governing board of the member or associate member school may, by formally adopted policy if among its own attendance centers, or by written agreement with the governing board of another member or associate member school, provide for the eligibility of its students in interscholastic activities provided by another member or associate member school. The eligibility of students under a policy, insofar as applicable, or a written agreement is conditioned upon the following:

36.20(1) All terms and conditions of the agreement are in writing;

36.20(2) The attendance boundary of each school that is party to the agreement is contiguous to or contained within the attendance boundary of one of the other schools, unless the activity is not offered at any school contiguous to the party district, or all schools that are contiguous refuse to negotiate an agreement with the party district, in which case the contiguous requirement may be waived by the applicable governing organization. For the purposes of this rule, a nonpublic school member will utilize the attendance boundaries of the public school in which its attendance center is located;

36.20(3) Any interscholastic activity not available to students of the schools participating in the agreement may be included in the agreement. A school's students may be engaged in cooperative activities under the terms of only one agreement;

However, if several schools are in a consortia cooperative agreement for a specific activity, they are not precluded from having a separate agreement with one or more of the same schools for a different activity as long as all schools of the consortia agree to such a separate agreement.

36.20(4) Agreements shall be for a minimum of one school year. Amendments may be made to agreements, including allowing additional member schools to join an existing agreement, without necessarily extending the time of existence of the agreement.

36.20(5) All students participating under the agreement are enrolled in one of the schools, are in good standing and meet all other eligibility requirements of these rules;

36.20(6) A copy of the written agreement between the governing boards of the particular schools involved, and all amendments to the agreement, shall be filed with the appropriate governing organization(s) no later than April 30 for the subsequent year, unless exception is granted by the organization for good cause shown. The agreements and amendments shall be deemed approved unless denied by the governing organization(s) within ten calendar days;

36.20(7) It is the purpose of this rule to allow individual students participation in interscholastic competition in activities not available to them at the school they attend, through local policy or arrangements made between the governing boards of the schools involved, so long as the interscholastic activities of other schools are not substantially prejudiced. Substantial prejudice shall include, but not necessarily be limited to, situations where a cooperative effort may result in an unfair domination of an activity or substantial disruption of activity classifications and management. In the event an activity organization determines, after investigation, that an agreement between schools that was developed under the terms of this rule results in substantial prejudice to other schools engaged in the activity, or the terms of the agreement are not in conformity with the purpose and terms of this rule, the activity organization may give timely notice to the schools involved that the local policy or agreement between them is null and void for the purposes of this rule, insofar as cooperative student participation is concerned with a particular activity. Determinations are appealable to the director of education under the applicable terms of 281—36.17(280). For notice to be timely, it must be given at least 45 calendar days prior to the beginning of the activity season.

This rule shall become effective on January 8, 1986. However, prior written agreements in existence at the time of this rule's adoption shall continue in force and effect until terminated by the parties or by the terms of the existing agreement.

This rule is intended to implement Iowa Code section 280.13.
[ARC 9475B, IAB 4/20/11, effective 5/25/11]

¹ See last paragraph of this rule.

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[◊] Two or more ARCs

¹ See rule 36.20, last paragraph.

² See Education, Department of[281], IAB.

TITLE VIII
SCHOOL TRANSPORTATIONCHAPTER 43
PUPIL TRANSPORTATION

[Prior to 9/7/88, see Public Instruction Department[670] Ch 22]

DIVISION I
TRANSPORTATION ROUTES**281—43.1(285) Intra-area education agency routes.**

43.1(1) Bus routes within the boundaries of transporting districts as well as within designated areas must be as efficient and economical as possible under existing conditions. Duplication of service facilities shall be avoided insofar as possible.

43.1(2) A route shall provide a load of at least 75 percent capacity of the bus.

43.1(3) The riding time, under normal conditions, from the designated stop to the attendance center, or on the return trip, shall not exceed 75 minutes for high school pupils or 60 minutes for elementary pupils. (These limits may be waived upon request of the parents.)

43.1(4) Pupils whose residence is within two miles of an established stop on a bus route are within the area served by the bus and are not eligible for parent or private transportation at public expense to the school served by the bus, except as follows:

a. Bus is fully loaded.

b. Physical handicap makes bus transportation impractical.

All parents or guardians who are required by their school district to furnish transportation for their children up to two miles to an established stop on a bus route shall be reimbursed pursuant to Iowa Code subsection 285.1(4).

43.1(5) Transporting districts shall arrange routes to provide the greatest possible convenience to the pupils. Distance pupils who are required to transport themselves to meet the bus shall be kept to the minimum consistent with road conditions, uniform standards and legal requirements for locating bus routes.

43.1(6) Each bus route shall be reviewed annually for safety hazards.

281—43.2(285) Interarea education agency routes.

43.2(1) Joint consultation shall be held by the area education agency boards involved. The initial steps may be undertaken by the area education agency administrators. If there are no difficulties and agreement is reached, the route is approved and no further action need be taken.

43.2(2) If agreement is not reached in the initial attempt, the administrator of the area education agency in which the applying school is located shall advise the superintendent of reasons for failure to reach agreement and request that the superintendent revise the transportation plan to meet the objection and resubmit same.

43.2(3) If the area education agency boards do not reach agreement on the route, the home area education agency administrator shall forward the complete record of the case together with disapproved transportation plan to the state department of education. Every effort should be made, however, to settle the matter locally.

43.2(4) All legal provisions, standards and regulations applying to approval and operation of bus routes apply equally to interarea education agency bus routes.

43.2(5) All interarea education agency bus routes must be approved each year. If there has been no change in the designations, nor in the proposed route, transportation plan may be made and agreement indicated by letter.

DIVISION II
PRIVATE CONTRACTORS

281—43.3(285) Contract required. All private contractors wishing to transport pupils to and from school in privately owned vehicles must be under contract with the board of education. This requirement will not apply to individuals who transport their own children or other children on a not-for-hire basis.

The contract form used shall be that provided by the department of education. (Form TR-F-4-497)

281—43.4(285) Uniform charge. The contract must provide for a uniform charge for all pupils transported. No differentiations may be made between pupils of different districts except as provided in Iowa Code section 285.1(12).

281—43.5(285) Board must be party. The contractor may not arrange with individual families for transportation. The contractor undertakes to transport only those families indicated by the board of education.

281—43.6(285) Contract with parents. Parents, guardians, or custodians undertaking to transport other children for hire, in addition to their own, are private contractors. These individuals must be under contract, and must obtain an appropriate driver's license and a school bus driver's authorization.

281—43.7(285) Vehicle requirements. Any vehicle used, other than that used by individuals to transport their own children or other children on a not-for-hire basis, is considered to be a school bus and must meet all requirements for the type of vehicle used. (This requirement is not intended to restrict the use of passenger cars during the time the vehicles are not actually engaged in transporting school pupils.)

DIVISION III
FINANCIAL RECORDS AND REPORTS

281—43.8(285) Required charges. Full pro rata costs must be charged and collected for the transportation of all nonresident pupils. No differentiation may be made in charges due to differences in distance or grade in school.

281—43.9(285) Activity trips deducted. Transporting school districts which use their equipment for activity trips, or educational tours, or other types of transportation services as permitted in Iowa Code sections 285.10(9) and 285.10(10), must deduct the cost of trips from the total yearly transportation cost. In other words, costs may not be included in the pro rata costs which determine the charge to sending districts.

Accurate and complete accounting records must be kept so that the cost of transportation to and from school may be ascertained.

DIVISION IV
USE OF SCHOOL BUSES

281—43.10(285) Permitted uses listed. School buses may be used to transport pupils under the following conditions:

43.10(1) The program is a part of the regular or extracurricular program of a public school and has been so adopted and made a matter of record in the minutes of all the boards involved.

43.10(2) The pupils are enrolled in a public school.

43.10(3) The program or activity must be sponsored by a school or group of schools cooperatively and be under the direct control of a qualified teacher or recreational or playground director of a school district.

a. A regularly certificated teacher must be in charge of the program. Several or all schools may engage the same instructor on a cooperative basis.

b. In transporting pupils to Red Cross swimming classes a superintendent of schools may be designated by action of the district board as the supervisor or director of the activity and may use the Red Cross instructor to carry on the actual instruction in swimming.

c. If the Red Cross instructor holds a regular teacher's certificate issued by the board of educational examiners, the instructor can be named as general supervisor of the activity by the several schools.

43.10(4) The bus shall be driven by a regularly approved driver holding an appropriate driver's license and a school bus driver's authorization. In addition, the buses must be accompanied by a member of the faculty or other employee of the school or a parent or other adult volunteer as authorized by a school administrator who will be responsible for the conduct and the general supervision of the pupils on the bus and at the place of the activity. If the faculty member is an approved driver, that person can act both as a driver and faculty sponsor.

43.10(5) School buses may be used by an organization of, or sponsoring activities for, senior citizens, children, handicapped, and other persons and groups, and for transportation of persons other than pupils to activities in which pupils from the school are participants or are attending the activity or for which the school is a sponsor under the following conditions:

a. The "school bus" signs shall be covered and the flashing warning lamps and stop arm made inoperable when the bus is being used in a nonschool-sponsored activity.

b. Transportation outside the state of Iowa shall not be provided without the approval of the Federal Motor Carrier Safety Administration of the United States Department of Transportation.

c. A chaperone shall accompany each bus to assist the passengers in boarding and disembarking from the bus and to aid them in case of illness or injury.

d. The driver of the bus shall be approved by the local board of education and must possess an appropriate driver's license and a school bus driver's authorization.

e. The driver of the bus shall observe the maximum speed limits for school buses at all times.

43.10(6) Seating.

a. Each passenger shall have a comfortable seat.

b. Student passengers shall have a minimum of 13 inches of allowable seating per person.

c. For adult groups, no more than two persons shall occupy a 39-inch seat.

d. Standees are prohibited in all situations, whether the bus is transporting students or adults.

e. The maximum number of passengers shall never exceed the rated capacity of the vehicle as it is equipped.

281—43.11(285) Teacher transportation. Public school teachers who are transported should be included in the average number transported and should be charged the pro rata cost by the transporting district.

DIVISION V
THE BUS DRIVER

281—43.12(285) Driver qualifications. General character and emotional stability are qualities which must be given careful consideration by boards of education in the selection of school bus drivers. Elements that should be considered in setting a character standard are:

1. Reliability or dependability.
2. Initiative, self-reliance, and leadership.
3. Ability to get along with others.
4. Freedom from use of undesirable language.
5. Personal habits of cleanliness.
6. Moral conduct above reproach.
7. Honesty.
8. Freedom from addiction to narcotics or habit-forming drugs.
9. Freedom from addiction to alcoholic beverages or liquors.

281—43.13(285) Stability factors. Factors to be considered in determining emotional stability are:

43.13(1) Patience.

43.13(2) Considerateness.

43.13(3) Even temperament.

43.13(4) Calmness under stress.

281—43.14(285) Driver age. School bus drivers must be at least 18 years of age on or before August 1 preceding the opening of the school year for which a school bus driver's authorization is required.

281—43.15(285) Physical fitness. Except for insulin-dependent diabetics, an applicant for a school bus driver's authorization must undergo a biennial physical examination by a licensed physician or surgeon, osteopathic physician or surgeon, osteopath, qualified doctor of chiropractic, licensed physician assistant, or advanced registered nurse practitioner. The applicant must submit annually to the applicant's employer the signed medical examiner's certificate (pursuant to Federal Motor Carrier Safety Administration regulations 49 CFR Sections 391.41 to 391.49), indicating, among other requirements, sufficient physical capacity to operate the bus effectively and to render assistance to the passengers in case of illness or injury, and freedom from any communicable disease. At the discretion of the chief administrator or designee of the employer or prospective employer, the chief administrator or designee shall evaluate the applicant's ability in operating a school bus, including all safety equipment, in providing assistance to passengers in evacuation of the school bus, and in performing other duties required of a school bus driver.

281—43.16(285) Tests for tuberculosis. Rescinded IAB 8/16/06, effective 9/20/06.

281—43.17(285) Insulin-dependent diabetics. A person who is an insulin-dependent diabetic may qualify to be a school bus driver if the person meets all qualifications of Iowa Code subsection 321.375(3). Such driver is subject to an annual physical examination by a qualified medical examiner as listed in rule 281—43.15(285).

281—43.18(285) Authorization to be carried by driver. Every school bus driver shall carry a copy of the driver's school bus driver's authorization at all times when the driver is acting in that capacity.

281—43.19(285) Vision requirements. Rescinded IAB 12/8/04, effective 1/12/05.

281—43.20(285) Hearing requirements. Rescinded IAB 12/8/04, effective 1/12/05.

281—43.21(285) Experience, traffic law knowledge and driving record. No driver applicant shall be employed or allowed to transport students until the board determines that the applicant has an acceptable driving record, demonstrates the ability to safely operate the vehicle(s) representative of the vehicle(s) required to be operated during employment and is knowledgeable of traffic laws and regulations pertaining to the operation of a school bus.

281—43.22(321) Fee collection and distribution of funds. The department of education, commencing with the biannual school bus inspections for the 2002-2003 school year and each year thereafter, shall assess a fee for each school bus or allowable alternative vehicle (pursuant to rule 761—911.7(321)) inspected by the department. The department shall present for payment a fee statement to the owner of each school bus or allowable alternative vehicle inspected.

The department of education shall submit an annual budget request for an amount equal to 100 percent of the total projected fees to be collected during the next fiscal year which shall be based on an amount equal to the number of school bus and allowable alternative vehicle inspections completed during the previous school year multiplied by the inspection fee authorized by statute.

One component of the annual budget shall be an annual "school bus driver and passenger safety education plan." The plan shall outline the projects and activities to be included during each year. These projects and activities may include, but not be limited to, curriculum development costs, printing and

distribution of safety literature and manuals, purchase of equipment used in conducting school bus safety education programs, and other expenditures deemed appropriate by the department of education.

281—43.23(285) Application form. The school bus driver and the board of education shall submit an application for the school bus driver's authorization annually, and upon a form prescribed by the department of education.

281—43.24(321) Authorization denials and revocations. A person who believes that a school bus driver who holds an authorization issued by the department of education or who seeks a school bus authorization has committed acts in violation of Iowa Code subsection 321.375(2) or rule 43.12(285) may file a complaint with the department against the driver or applicant. The department shall notify the driver or applicant that a complaint has been filed and shall provide the driver or applicant with a copy of the complaint. A hearing shall be set for the purpose of determining whether the bus driver's authorization shall be denied, suspended, or revoked, or whether the bus driver should receive a reprimand or warning. Hearing procedures in 281—Chapter 6 shall be applicable to such proceedings.

DIVISION VI
PURCHASE OF BUSES

281—43.25(285) Local board procedure. The board of education shall proceed as follows in purchasing school buses:

43.25(1) Rescinded IAB 12/15/10, effective 1/19/11.

43.25(2) Notify dealers of intent to purchase school transportation equipment and request bids.

43.25(3) Reserve right to reject all bids.

43.25(4) Require all bids to be on comparable equipment which meets all state and federal requirements.

43.25(5) Hold an open meeting for dealers to present merits of their equipment.

43.25(6) Review bids, tabulate all bids, make a record of action taken.

43.25(7) Sign contracts or orders for purchase of school transportation equipment. The purchase agreement must provide that the dealer will deliver equipment which will pass initial state inspection at no further cost to the school and further provide that the school board shall withhold at least \$150 until the vehicle passes initial state inspection.

43.25(8) Notify the bureau of nutrition programs and school transportation of the state department of education of purchase and date of delivery so that arrangements can be made for the initial school bus inspection. No school bus can be put into service until it has passed a pre-use inspection conducted pursuant to Form TR-F-27B by the local board of education and the form has been provided to the bureau of nutrition programs and school transportation. The initial school bus inspection will be conducted at the earliest possible time convenient to the school and the department of education.

[ARC 9262B, IAB 12/15/10, effective 1/19/11]

281—43.26(285) Financing. The board of education may finance purchase of transportation equipment as follows:

43.26(1) The board may pay all of the cost of each bus from funds on hand in general fund.

43.26(2) Bonds may be voted to purchase equipment, and funds so derived shall be used for that purpose.

281—43.27 to 43.29 Reserved.

DIVISION VII
MISCELLANEOUS REQUIREMENTS

281—43.30(285) Semiannual inspection. To facilitate the semiannual inspection program, school and school district officials shall send their buses to inspection centers as scheduled. A sufficient number of drivers or other school personnel shall be available at the inspection to operate the equipment for the

inspectors. The fee for each vehicle inspected shall be \$20 effective July 1, 2005; \$25 effective July 1, 2007; and \$28 effective July 1, 2009.

281—43.31(285) Maintenance record. School officials shall cause the chassis of all buses and allowable alternative vehicles, whether publicly or privately owned, to be inspected annually and all necessary repairs made before the vehicle is put into service. The inspection and repairs shall be recorded on a form (TR-F-27A) prescribed by the department of education. The completed form (TR-F-27A) shall be signed by the mechanic and carried in the glove compartment of the bus.

281—43.32(285) Drivers’ schools. All school bus drivers shall attend classes or schools of instruction as approved by the department of education and provided for in Iowa Code subsection 321.376(2). All new drivers shall, within the first six months of employment, successfully complete the “new driver STOP class” approved by the department. All current school bus drivers shall attend the annual course of instruction. Upon missing a year of instruction, a current driver shall successfully complete the course of instruction for new drivers prior to receiving an authorization. The employer of a school bus driver may impose additional training requirements for any new or current driver.
[ARC 9472B, IAB 4/20/11, effective 5/25/11]

281—43.33(285) Insurance. The board of education shall carry insurance on all school-owned buses and see that insurance is carried by all contractors engaged in transporting pupils for the district in the coverages and limits as determined by the board of education.

281—43.34(285) Contract—privately owned buses. The board of education and a contractor who undertakes to transport school pupils for the board, in privately owned vehicles, shall sign a contract substantially similar to that prescribed by the department of education (Form TR-F-4-497). The contract shall contain the following provisions:

43.34(1) To furnish and operate at the contractor’s own expense a legally approved vehicle of transportation (or a legally approved chassis on which may be mounted a school bus body supplied and maintained by the board of education) to and from the school each day beginning on the date set by the board over route as described, transporting only children attending the school designated by the board of education.

43.34(2) To comply with all legal and established uniform standards of operation as required by statute or by legally constituted authorities.

43.34(3) To comply with all uniform standards, established for protection of health and safety for pupils transported.

43.34(4) To comply with all rules and regulations adopted by the board of education for the protection of the children, or to govern the conduct of driver of bus.

43.34(5) To keep bus in good mechanical condition and up to standards required by statutes or by legally constituted authorities.

43.34(6) To take school bus to official inspection when held by state authorities with no additional expense to party of second part.

43.34(7) To see that the bus is swept and the windows cleaned each day and that registration plates and all lights are cleaned before each trip. Further, that the bus is washed and the floor swept and scrubbed with a good disinfectant each week. In case of an epidemic the entire bus shall be washed with a disinfectant.

43.34(8) To use only drivers and substitute drivers who have been approved by the board of education and have received a school bus driver’s authorization.

43.34(9) To furnish the board of education an approved certificate of medical examination for each person who is approved by the board of education to drive the bus.

43.34(10) To attend a school of instruction for bus drivers as prescribed by the bureau of nutrition programs and school transportation of the department of education. (If the owner does not drive the bus, the regular approved driver of the bus shall attend.).

43.34(11) To carry insurance on bus and pupils in the coverages and limits as determined by the board of education. Copy of policy to be filed with superintendent of schools.

43.34(12) To make such reports as may be required by state department of education, area education agency board of education, and superintendent of schools.

43.34(13) That the school bus shall be used only for transporting regularly enrolled students to and from public school and to extracurricular activities approved and designated by the board of education and further to comply with all legal restrictions on use of bus.

43.34(14) To obtain, if possible, the registration numbers of all cars violating the school bus passing law, Iowa Code section 321.372 and file information for prosecution.

43.34(15) The board of education hereby reserves the right to change routing of the bus and, if additional mileage is required, it shall be at an extra cost not exceeding \$ per additional mile per month. If shortened.

43.34(16) Immoral conduct or the use of alcoholic beverages by the contractor or driver employed by the contractor shall result in appropriate sanctions as provided in Iowa Code section 321.375.

43.34(17) Contract may be terminated on 90-day notice by either party, Iowa Code section 285.5(4).

43.34(18) The contractor agrees that, if the contractor desires to terminate the contract, the school bus will be sold to the board of education at its request as provided in Iowa Code section 285.5(1). (This requirement does not apply to a passenger auto used as a school bus.)

[ARC 9262B, IAB 12/15/10, effective 1/19/11]

281—43.35(285) Contract—district-owned buses. The board of education and a private individual undertaking to transport school pupils for the board in school district-owned vehicles shall sign a contract substantially similar to that prescribed by the department of education (Form TR-F-5-497(revised)). The contract shall contain the following provisions:

43.35(1) To conform to all rules of the board of education in and for the district adopted for the protection of the children and to govern the conduct of the person in charge of the conveyance.

43.35(2) To make reports as may be required by the state department of education, area education agency, or superintendent of schools.

43.35(3) To conform to all standards for operation of the school buses as required by statute or by legally constituted authorities.

43.35(4) That the employee shall be entitled to benefits as outlined in the school board policy for the school district.

43.35(5) To attend a school of instruction for bus drivers as prescribed by the bureau of nutrition and school transportation of the department of education.

43.35(6) That the employer can terminate the contract and dismiss the employee for failure to conform to all laws of the state of Iowa and rules promulgated by the Iowa department of education applicable to drivers of school buses.

43.35(7) That this contract shall not be in force until the driver presents an official school bus driver’s authorization.

281—43.36(285) Accident reports. The superintendent of schools shall make a report to the bureau of nutrition and school transportation of the department of education on any accident involving any vehicle in use as a school bus. The driver of the bus shall cooperate with the superintendent in making the report. The report shall be made on the department of transportation Iowa Accident Report Form.

281—43.37(285) Railroad crossings. The driver of any school bus shall bring the bus to a complete stop at all railroad crossings, as required in Iowa Code section 321.343, regardless of whether or not there are any pupils in the bus, and regardless of whether or not there is an automatic signal at the crossing. After stopping, the driver shall open the entrance door, look and listen for approaching trains and shall not proceed to cross the tracks until it is safe to do so.

281—43.38(285) Driver restrictions.

43.38(1) The driver of a school bus shall not smoke on the bus or on any school property.

43.38(2) The driver shall not permit firearms to be carried in the bus.

43.38(3) The driver shall not fill the fuel tank while the motor is running or when there are passengers on the bus.

43.38(4) The driver shall ensure that aisles and exits are not blocked.

[ARC 9262B, IAB 12/15/10, effective 1/19/11]

281—43.39(285) Civil defense projects. Civil defense projects may be recognized by the board of directors of any school district as an authorized extracurricular activity under the following conditions:

43.39(1) Such activity may take the form of, but need not be restricted to:

- a. First-aid classes.
- b. Study and distribution of materials relating to community survival, fallout shelters, radiation detection, and other pertinent disaster measures.
- c. Exercises and field trips related to the above matters.
- d. Cooperation with local, state and national authorities, both civil and military, and interested organizations, in carrying out civil defense exercises and in planning and making preparations for passive defense in time of actual emergency.

43.39(2) The use of school buses for field trips and exercises, and the planned use of school buses in connection with actual emergency procedures to be carried on in cooperation with local, state or national authorities, civil or military, is hereby defined as properly incident to such authorized extracurricular activity.

43.39(3) All such projects, except an actual emergency operation where time is of the essence, shall have prior approval of the state department of education.

43.39(4) The bus shall be driven by an approved driver holding an appropriate driver's license and a regular school bus driver's authorization except that in actual emergency situations, where regular drivers are not available, certain other drivers, including students and teachers, may be used providing the following conditions are met. The driver shall:

- a. Be approved by the local board of education.
- b. Be at least 18 years of age, be physically and mentally competent, and not possess personal or moral habits which would be detrimental to the best interests of the safety and welfare of the children transported.

43.39(5) Rescinded IAB 12/8/04, effective 1/12/05.

281—43.40(285) Pupil instruction. At least twice during each school year, each pupil who is transported in a school vehicle shall be instructed in safe riding practices and participate in emergency evacuation drills.

281—43.41(285) Trip inspections. A pretrip inspection of each school bus shall be performed and recorded prior to each trip. A written report shall be submitted promptly to the superintendent of schools, transportation supervisor, school bus mechanic, or other person charged with the responsibility for the school transportation program, if any defects or deficiencies are discovered that may affect the safety of the vehicle's operation or result in its mechanical breakdown. A posttrip inspection of the interior of the school bus shall be performed after each trip.

281—43.42(285) Loading and unloading areas. Restricted loading and unloading areas shall be established for school buses at, or near schools.

281—43.43(285) Communication equipment. Each school bus shall have a two-way communications system or cellular telephone capable of emergency communication between the driver of the bus and the school's base of operations for school transportation.

DIVISION VIII
COMMON CARRIERS

281—43.44(285) Standards for common carriers. These standards are intended to apply to any vehicle operated by a common carrier when used exclusively for student transportation to and from school.

43.44(1) Vehicles.

a. The vehicles need not be painted yellow and black as required for conventional school buses.

b. The vehicles shall, while transporting children to and from school, be equipped with temporary signs, located conspicuously on the front and back of the vehicle. The sign on the front shall have the words “School Bus” printed in black letters not less than six inches high, on a background of national school bus glossy yellow. The sign on the rear shall be at least ten square feet in size and shall be painted national school bus glossy yellow, and have the words “School Bus” printed in black letters not less than eight inches high. The yellow is to be in accordance with the colorimetric specification of Federal Standard No. 595a, Color 13432; the black matching Federal Standard 595a, Color 17038. Both the six-inch and eight-inch letters shall be Series “D” as specified in the Standard Alphabet—Federal Highway Administration, 1966.

c. Rescinded, effective 8/11/82.

43.44(2) Drivers.

a. The driver shall have an appropriate driver’s license issued by the Iowa department of transportation.

b. The driver shall possess a school bus driver’s authorization issued by the Iowa department of education.

c. The driver shall receive training in accordance with state requirements for school bus drivers.

43.44(3) Seating.

a. Each passenger shall have a comfortable seat.

b. Standees are prohibited.

43.44(4) Loading and unloading procedures.

a. Vehicle shall pull close enough to curb to prevent another vehicle from passing on right side.

b. If vehicle is not equipped with flashing warning lights or stop arm, or if use of this equipment is prohibited by law, the pupils, on unloading, shall be instructed to remain at the curb until bus has pulled away and it is safe for them to cross the street.

43.44(5) Inspection of vehicles.

a. Drivers shall be required to perform daily pretrip inspections of their vehicles and to report promptly and in writing any defects or deficiencies discovered that may affect the safety of the vehicle’s operation or result in its mechanical breakdown in accordance with rule 43.41(285).

b. Vehicles shall be inspected semiannually by personnel of the department of education in accordance with the provisions of Iowa Code section 285.8(4).

43.44(6) Other requirements.

a. Local school officials shall provide the carrier with passenger conduct rules and the driver shall abide by the policies and procedures established by the local district.

b. The carrier shall make a report to the bureau of nutrition and school transportation of the department of education on any accident involving property damage or personal injury while a vehicle is being used as a school bus. The report shall be made on the Iowa Accident Report Form.

c. Student instruction for passenger safety shall be the responsibility of the local school district as specified in rule 43.40(285).

These rules are intended to implement Iowa Code chapter 285.

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CHAPTER 81
STANDARDS FOR SCHOOL BUSINESS OFFICIAL PREPARATION PROGRAMS

281—81.1(256) Definitions.

“*Area education agency*” or “*AEA*” means a regional service agency that provides school improvement services for students, families, teachers, administrators, and the community.

“*Department*” means the department of education.

“*Director*” means the director of the department of education.

“*Institution*” means a public or private institution of higher education, an AEA, or a professional organization offering a school business official preparation program(s) and renewal credits.

“*Novice*” means an individual in a school business official position who has no previous experience in that position or who is newly authorized by the board of educational examiners.

“*School business official candidates*” means individuals who are enrolled in school business official preparation programs leading to authorization by the board of educational examiners to practice as school business officials.

“*School business official preparation programs*” means the programs of school business official preparation that lead to authorization to practice as a school business official.

“*State board*” means the Iowa state board of education.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.2(256) Institutions eligible to provide a school business official preparation program. Institutions of public and private higher education, AEAs, and professional organizations engaged in the preparation of school business officials shall meet the standards contained in this chapter in order to obtain and maintain state board approval of their programs. Each institution that seeks state board approval of its programs for school business official preparation shall file evidence of the extent to which each program meets the standards contained in this chapter. Such evidence shall be demonstrated by means of a written self-evaluation report and an evaluation conducted by the department and shall be prepared using a template developed by the department. Only approved programs may recommend candidates for school business official authorization.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.3(256) Approval of programs. Approval by the state board of an institution’s school business official preparation program shall be based on the recommendation of the director after study of the factual and evaluative evidence on record about each program in terms of the standards contained in this chapter.

81.3(1) Approval, if granted, shall be for a term of seven years; however, approval for a lesser term may be granted by the state board if it determines conditions so warrant.

81.3(2) If approval is not granted, the applicant institution will be advised concerning the areas in which improvement or changes appear to be essential for approval. In this case, the institution shall be given the opportunity to present factual information concerning its programs at a regularly scheduled meeting of the state board, no later than three months following the board’s initial decision.

81.3(3) Programs may be granted conditional approval upon review of appropriate documentation. In such an instance, the program shall receive a full review after one year or, in the case of a new program, at the point at which candidates demonstrate mastery of standards for authorization.

81.3(4) The standards herein apply regardless of delivery mode of instruction.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.4(256) Governance and resources standard. An institution’s governance structure and resources shall adequately support the preparation of school business official candidates to meet professional, state, and institutional standards in accordance with the following provisions.

81.4(1) A clearly understood governance structure provides guidance and support for the school business official preparation program.

81.4(2) Procedures for an appeals process for candidates are clearly communicated and provided to all candidates.

81.4(3) The program administers a comprehensive evaluation system designed to enhance the teaching competence and intellectual vitality of the professional educational institution.

81.4(4) Institutional commitment to the program includes financial resources, facilities, appropriate educational materials, media services including library services, and equipment to ensure the fulfillment of the institution's and program's missions and the delivery of quality programs.

81.4(5) The institution provides sufficient instructors and administrative, clerical, and technical staff to plan and deliver a quality school business official preparation program.

81.4(6) Resources are available to support professional development opportunities for instructors.

81.4(7) Resources are available to support technological and instructional needs to enhance candidate learning.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.5(256) Instructor standard. Instructor qualifications and performance shall facilitate the professional development of school business official candidates in accordance with the following provisions.

81.5(1) Instructors are adequately prepared for assigned responsibilities and have had experiences relative to the curricula the instructors are teaching and in situations similar to those for which the school business official candidates are being prepared. Instructors have experience and adequate preparation in effective methods for any mode of program delivery in which the instructors are assigned responsibilities.

81.5(2) Instructors instruct and model best practices in teaching, including the assessment of the instructors' own effectiveness as it relates to candidate performance.

81.5(3) Instructors are engaged in professional development that relates to school business official preparation.

81.5(4) Instructors collaborate regularly and in significant ways with colleagues in the institution and other institutions, schools, the department, and professional associations as well as with community representatives.

81.5(5) Part-time instructors and graduate assistants are identified as instructors and meet the background and experience requirements appropriate for the instructors' and assistants' assigned responsibilities.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.6(256) Assessment system and institution evaluation standard. The institution's assessment system shall appropriately monitor individual candidate performance and use the performance data in concert with other information to evaluate and improve the institution and its programs.

81.6(1) Program assessment system.

a. The program utilizes a clearly defined management system for the collection, analysis, and use of assessment data.

b. The institution clearly documents candidates' attainment of the program standards.

c. The institution demonstrates the propriety, utility, accuracy and fairness of both the overall assessment system and the instruments used and provides scoring rubrics or other criteria used in evaluation instruments.

d. The institution documents the quality of programs through the collective presentation of assessment data related to performance of school business official candidates. Documentation shall include the following:

(1) Data collected throughout the program, including data from all delivery models;

(2) Evidence of evaluative data collected from school business officials who work with the program's candidates; and

(3) Evidence of evaluative data collected by the institution through follow-up studies of graduates and their employers.

e. The institution explains the process for reviewing and revising the assessment system.

f. The institution demonstrates how the information gathered by the institution and from the performance assessment system for candidates is shared with instructors and other stakeholders and used for program improvement.

81.6(2) *Performance assessment system for candidates.*

a. The performance assessment system for candidates is an integral part of the institution's planning and evaluation system.

b. The performance assessment system for candidates includes a coherent, sequential assessment system for individual school business official candidates. The assessment system is shared with instructors to provide guidance for course and program improvement. The assessment system also provides ongoing feedback to school business official candidates about their achievement of program standards and guidance for reflection and improvement. Data are drawn from multiple formative and summative assessments of institutional evaluation of the candidates' content knowledge and professional knowledge and from application of this knowledge to the necessary skills and attributes appropriate for a novice school business official.

c. School business official candidate performance is assessed at the same standard regardless of the place or manner in which the program is delivered.

81.6(3) *Annual reports.* The institution annually reports to the department such data as are required by the state and federal governments at dates determined by the department.

81.6(4) *Survey of graduates.* The department periodically conducts a survey of schools, agencies, or facilities that employ licensed graduates of approved programs to ensure that the graduates' needs are adequately met by their programs and by the approval process herein.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.7(256) School business official candidate knowledge and skills standard. School business official candidates shall demonstrate the content knowledge and professional knowledge and skills in accordance with the following provisions.

81.7(1) Each school business official candidate shall demonstrate through coursework the knowledge, skills, and other attributes necessary to meet the following standards at a level appropriate for a novice school business official. Each school business official candidate shall acquire the content knowledge and demonstrate competencies in the following areas:

a. Accounting (GAAP) concepts: fund accounting, account codes, Uniform Financial Accounting.

b. Accounting cycles: budgets, payroll/benefits, purchasing/inventory, cash, receipts, disbursements, financial reporting, investments.

c. Technology: management of accounting systems, proficiency in understanding and use of systems technology and related programs.

d. Regulatory: Uniform Administrative Procedures Manual, school policies and procedures, administrative procedures, public records law, records management, school law, employment law, construction and bidding law.

e. Personal skills: effective communication and interpersonal skills, ethical conduct, information management, ability to analyze and evaluate, ability to recognize and safeguard confidential information, and accurate and timely performance.

f. Participation in the board of educational examiners ethics program.

g. Participation in the school business official mentoring program.

h. Promotion of the value of the school business official's fiduciary responsibility to the taxpayer.

81.7(2) Each school business official candidate shall meet all requirements established by the board of educational examiners for an authorization for which the candidate is recommended. Programs shall submit curriculum exhibit sheets for approval by the board of educational examiners and the department.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.8(256) School business official mentoring program. The one-year mentoring program and its partners shall assist candidates in becoming successful school business officials in accordance with

the following provisions. The candidate must be employed as a school business official to be eligible to participate in the mentoring program.

81.8(1) Candidates admitted to a school business official preparation program shall participate in the mentoring program. All hours spent in the mentoring program are outside of the nine semester hours required in the program.

81.8(2) Each school business official preparation program shall inform all candidates of the following minimum expectations of the candidates as mentees:

a. Participation in weekly conversations with the mentee's mentor, including a review of work assignments.

b. Maintenance of a record of contacts with the mentor and submission of the record to the program. A template will be provided by the program.

c. Completion of surveys to assist with program evaluation.

d. Communication with the program if the relationship with the mentee's mentor is not meeting the needs or expectations of the mentee.

e. Full participation in the mentoring program throughout the one-year period.

81.8(3) Each school business official preparation program shall inform all program candidate mentors of the following minimum expectations:

a. Contacting the mentee on a weekly basis.

b. Completing surveys to assist with program evaluation.

c. Informing the program if the relationship with the mentee is not meeting expectations.

d. Maintaining confidentiality of the interactions between mentor and mentee.

e. Supporting the mentee throughout the one-year period.

81.8(4) The institution shall offer one or more workshops annually for all cooperating mentors to define the objectives of the mentoring program, review the responsibilities of the cooperating mentors, and provide the cooperating mentors other information and assistance the institution deems necessary. The workshops shall utilize delivery strategies identified as appropriate for staff development and reflect information gathered through feedback from workshop participants.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.9(256) Periodic reports. Upon request by the department, programs shall make periodic reports which shall include, but not be limited to, basic information necessary to maintain up-to-date records of each school business official preparation program and to carry out research studies relating to school business official preparation.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.10(256) Reevaluation of school business official preparation programs. Every seven years or at any time deemed necessary by the director, an institution shall file a written self-evaluation of its school business official preparation program. Any action for continued approval or rescission of approval shall be approved by the state board.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

281—81.11(256) Approval of program changes. Upon application by an institution, the director is authorized to approve minor additions to or changes within the curriculum of an institution's approved school business official preparation program. When an institution proposes a revision that exceeds the primary scope of its programs, the revision shall become operative only after approval by the state board.

[ARC 9474B, IAB 4/20/11, effective 5/25/11]

These rules are intended to implement Iowa Code section 256.7 as amended by 2010 Iowa Acts, chapter 1099.

[Filed ARC 9474B (Notice ARC 9379B, IAB 2/23/11), IAB 4/20/11, effective 5/25/11]

CHAPTER 82
OCCUPATIONAL AND POSTSECONDARY CERTIFICATION AND ENDORSEMENTS

[Prior to 9/7/88, see Education Department[281]Ch 74]

[Transferred to Educational Examiners[282] Ch 16, IAC 10/3/90, effective 9/14/90]

TITLE XVI
SCHOOL FACILITIESCHAPTER 96
STATEWIDE/LOCAL OPTION SALES AND
SERVICES TAX FOR SCHOOL INFRASTRUCTURE

281—96.1(423E,423F) Definitions. For purposes of these rules, the following definitions shall apply:

“Actual enrollment” means the number of students each school district certifies to the department by October 15 of each year in accordance with Iowa Code section 257.6, subsection 1.

“Base year” means the school year ending during the calendar year in which the budget is certified.

“Certificate of need” means the written department of education approval a school district must obtain if the district has a certified enrollment of fewer than 250 students or a certified enrollment of fewer than 100 students in grades 9-12. The certificate of need must be obtained by the school district before the district may expend the supplemental school infrastructure amount for new construction or for payments for bonds issued for new construction against the supplemental school infrastructure amount or to expend the statewide sales and services amount or remaining unobligated local option sales and services balances for new construction.

“Combined actual enrollment” means the sum of the students in each school district located in whole or in part in a county who are residents of that county as determined by rule 281—96.2(423E,423F).

“Department” means the state department of education.

“Guaranteed school infrastructure amount” means for a school district the statewide tax revenues per student, multiplied by the quotient of the tax rate percent imposed in the county, divided by 1 percent and multiplied by the quotient of the number of quarters the tax is imposed during the fiscal year divided by four quarters.

“New construction” means any erection of a facility or any modification or addition to a facility except for repairing existing schoolhouses or school buildings or for construction necessary for compliance with the federal Americans with Disabilities Act pursuant to 42 U.S.C. Section 12101-12117.

“Nonresident student” means a student enrolled in a school district who does not meet the requirements of a resident as defined in Iowa Code section 282.1.

“Reconstruction” means rebuilding or restoring as an entity a thing that was lost or destroyed.

“Repair” means restoring an existing structure or thing to its original condition, as near as may be, after decay, waste, injury, or partial destruction, but does not include maintenance.

“Resident student” means a student enrolled in a school district who meets the requirements of a resident as defined in Iowa Code section 282.1.

“Revenue purpose statement” means a document prepared by the school district indicating the specific purpose or purposes for which the funding, pursuant to Iowa Code chapters 423E and 423F, will be expended.

“Sales tax” means a local option sales and services tax for school infrastructure imposed in accordance with Iowa Code chapter 423E and the statewide sales and services tax for school infrastructure imposed in accordance with Iowa Code chapter 423F.

“Sales tax capacity per student” means for a school district the estimated amount of revenues that a school district receives or would receive if a local sales and services tax for school infrastructure purposes is imposed at 1 percent in the county, divided by the school district’s actual enrollment.

“School budget review committee” or *“SBRC”* means a committee that is established under Iowa Code section 257.30 in the department of education and that consists of the director of the department of education, the director of the department of management, and three members who are knowledgeable in the areas of Iowa school finance or public finance issues and who are appointed by the governor to represent the public.

“School district” means a public school district in Iowa accredited by the state department of education.

“*School infrastructure*” means those activities for which a school district is authorized to contract indebtedness and issue general obligation bonds under Iowa Code section 296.1, except those activities related to a teacher’s or superintendent’s home or homes. These activities include the construction, reconstruction, repair, demolition, purchase, or remodeling of schoolhouses, stadiums, gymnasiums, fieldhouses, and bus garages; the procurement of schoolhouse sites and site improvements; and the payment or retirement of general obligation bonds issued for school infrastructure purposes or of sales and services tax for school infrastructure revenue bonds. The definition of school infrastructure also includes activities for which revenues under Iowa Code sections 298.3 and 300.2 may be spent and property tax relief for the debt service property tax levy, regular physical plant and equipment property tax levy, voter-approved physical plant and equipment income surtax and property tax levy, and the public education and recreation property tax levy.

“*Site improvement*” means grading, landscaping, paving, seeding, and planting of shrubs and trees; constructing sidewalks, roadways, retaining walls, sewers and storm drains, and installing hydrants; surfacing and soil treatment of athletic fields and tennis courts; exterior lighting, including athletic fields and tennis courts; furnishing and installing flagpoles, gateways, fences, and underground storage tanks which are not parts of building service systems; demolition work; and special assessments against the school district for public improvements defined in Iowa Code section 384.37.

“*Statewide tax revenues per student*” means the amount per student established by Iowa Code subsection 423E.4(2) “b”(3).

“*Supplemental school infrastructure amount*” means the guaranteed school infrastructure amount for the school district less the pro rata share of local sales and services tax for school infrastructure purposes.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

281—96.2(423E,423F) Reports to the department. Each school district shall, by October 15, annually report the school district’s actual enrollment on October 1 by the student’s county of residency according to the following:

96.2(1) *County of residency.* The county of residency for each of the students shall be the county in which the student lives in accordance with Iowa Code section 282.1.

96.2(2) *Emancipated minor.* The county of residency for an emancipated minor attending the school district shall be the county in which the emancipated minor is living.

96.2(3) *County of residency unknown.* If a school district cannot determine an enrolled student’s county of residency or if the county of residency is not a county in which the school district is located, the county of residency shall be the county in which the school district certifies its budget.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

281—96.3(423E,423F) Combined actual enrollment. By March 1, annually, the department shall forward to the department of management the actual enrollment and the actual enrollment by the student’s county of residency for each school district located in whole or in part in a county where a sales tax has been imposed and the combined actual enrollment for that county.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

281—96.4(423E,423F) Application and certificate of need process.

96.4(1) *When application needed; application period.* After July 1, 2008, a school district with a certified enrollment of fewer than 250 students in the entire district or a certified enrollment of fewer than 100 students in grades 9 through 12 shall not expend the amount of statewide or local sales and services tax received for new construction without prior application to the department and receipt of a certificate of need. A certificate of need is not required for repair of school facilities; for purchase of equipment, technology, or transportation equipment for transporting students as provided in Iowa Code section 298.3; or for construction necessary to comply with the federal Americans With Disabilities Act, 42 U.S.C. Sections 12101 to 12117. Applications shall be hand-delivered or postmarked no later than eight weeks prior to a regularly scheduled meeting of the SBRC. Delivery of applications by way of

facsimile transmission is not allowed. The SBRC holds regularly scheduled meetings on the second Monday of September, December, March, and May.

96.4(2) Application form. The department shall make available an application form to Iowa public school districts. Each applicant school district shall use the form prepared for this purpose and in the manner prescribed by the department. A school district may submit only one application during the application period. The application form shall include, but shall not be limited to, the following information:

a. The total capital investment of the project. If the project is in collaboration with other public or private entities, a school district shall include the following information:

- (1) Identification of the collaborating public or private entities;
- (2) Total cost of the collaborative project; and
- (3) Total cost of the school district's portion of the project.

b. The infrastructure needs of a school district specific to the application, especially the fire and health safety needs, including the extent to which the project would allow the school district to meet its infrastructure needs on a long-term basis. If a school district's needs include fire and health safety needs, the school district shall attach to its application form a copy of the citation from the fire marshal for the safety deficiency or evidence of consultation with the fire marshal or other qualified inspector related to the health safety deficiency. A school district shall include evidence of public involvement in assessing the need for this project.

c. The description of need including documentation of the infeasibility of remodeling, reconstructing, or repairing the existing structure rather than implementing this project and a description of any alternatives considered and the reasons for rejection.

d. Enrollment trends by grade in a school district showing a five-year history and five years of projected enrollment by grade. The school district shall identify the grades that will be served at the new construction site. If a school district uses enrollment projections other than those prepared by the department, the school district must submit a description of the basis for those projections. The school district shall demonstrate that there is sufficient economic activity and stability to support and sustain enrollment projections of the affected attendance center.

e. If a school district's enrollment in the current year or any of the five years of projected enrollments is fewer than 250 students, the school district shall attach a copy of a feasibility study pursuant to Iowa Code subsection 256.9(34) or similar study conducted within the past three years with an explanation of how the study supports the project that is the subject of the application.

f. A description of the nature of the project and its relationship to improving educational opportunities for students including alignment with school district student achievement goals and including the school district's ability to meet or exceed the educational standards. A school district shall provide:

(1) A list of waivers applied for and granted to the school district or any deficiencies from educational standards if no waiver was granted.

(2) A list of courses offered by major curricular area in grades 9 through 12. The list shall include five years of history and three years of projected curricula if the proposed new construction will house any of the grades 9 through 12.

(3) A list of current and projected staffing patterns including assignments and licensure.

g. Description of transportation barriers, if any, to the current site and to the proposed site and the distance in miles and in travel time from the nearest and furthest boundaries of the school district to the current site and the proposed site.

h. Evidence of a healthy financial condition and long-term financial stability. The school district shall provide:

(1) Calculation of unspent balance on the generally accepted accounting principles (GAAP) basis. The calculation shall include five years of history and three years of projected balances. The calculation of budget authority shall show and project the effect of the phaseout of the budget guarantee. Projected allowable growth shall be that known or generally anticipated at the time of the application. If the percent

of allowable growth is not known or anticipated, an allowable growth of no more than 2 percent shall be utilized in the annual projections.

(2) If the unspent balance is negative in any current or projected year on the GAAP basis, the school district shall include a copy of the corrective action plan, if any, submitted to the SBRC.

(3) Calculation of fund balance on the GAAP basis by fund. The calculation shall include five years of history and three years of projected balances.

i. If a school district currently has bonded indebtedness, the voter-approved physical plant and equipment levy, or categorical funding for school infrastructure, the school district shall include a statement identifying the implementation date, final year of the bonded indebtedness or the final year of the levy or categorical funding, and the levy rate. The school district shall list any obligations against those current balances and future revenues or against the local option or statewide sales and services tax for school infrastructure amounts. The school district shall attach a copy of the school district's revenue purpose statement, if any.

j. A comprehensive, districtwide infrastructure plan. The school district shall include the date that the plan was adopted by the board, an executive summary of the plan, and a description of how the project fits within the infrastructure plan.

k. A five-year history of significant infrastructure maintenance and repair.

l. A statement certifying the accuracy of the information contained in the application.

96.4(3) Board minutes. A school district that is submitting an application for certificate of need shall submit with its application a copy of the published minutes of the board of director's meeting showing that the board has authorized the application and the project and that the public has been informed. The section of the board minutes containing this information shall be marked in such a way as to make it easily identifiable.

96.4(4) Number of copies. A school district that is submitting an application for certificate of need shall submit three complete sets of the application forms and board minutes with original signatures on the application forms.

96.4(5) Reapplication. A school district that is not successful in obtaining a certificate of need for the project that is the subject of the application may apply for a certificate of need in succeeding application periods if its circumstances change substantially.

96.4(6) Application timeline. A school district shall submit an application for a certificate of need either:

a. When the school district has received amounts that it intends to accumulate for new construction or for payment of debt related to new construction; or

b. When the school district board has accumulated amounts and wants to proceed with the new construction project or debt issuance related to new construction, whichever occurs first.

96.4(7) Compliance requirement on uses. All projects included in the application must be consistent with the provisions of the Americans With Disabilities Act and the Rehabilitation Act of 1973, Section 504, and Iowa Code chapter 104A.

[ARC 8384B, IAB 12/16/09, effective 1/20/10; ARC 9473B, IAB 4/20/11, effective 5/25/11]

281—96.5(423E,423F) Review process.

96.5(1) Task force. The department shall form a task force to review applications for certificate of need and to provide recommendations to the SBRC. The department shall invite participants from large, medium, and small school districts, the state fire marshal's office, education and professional organizations, or other individuals knowledgeable in school infrastructure and construction issues. The department, in consultation with the task force, shall establish the parameters and criteria for awarding certificates of need based on information listed in Iowa Code section 423E.4, subsection 5, which includes required consideration of the following:

a. Enrollment trends in the grades that will be served at the new construction site.

b. The infeasibility of remodeling, reconstructing, or repairing existing buildings.

c. The fire and health safety needs of the school district.

d. The distance, convenience, cost of transportation, and accessibility of the new construction site to the students to be served at the new construction site.

e. Unavailability of alternative, less costly, or more effective means of serving the needs of the students.

f. The financial condition of the school district, including the effect of the decline of the budget guarantee and unspent balance.

g. Broad and long-term ability of the school district to support the facility and the quality of the academic program.

h. Cooperation with other educational entities including other school districts, area education agencies, postsecondary institutions, and local communities.

96.5(2) *Task force review.* The task force, or a subcommittee of the task force, and its designees, shall review each application and make recommendations to the school budget review committee regarding approval of certificates of need based on the evidence provided by the applicant pursuant to subrule 96.4(2) and the criteria listed in subrule 96.5(1). More than one member of the task force or subcommittee of the task force and its designees shall review each application. A reviewer shall not review any application in which the reviewer has a conflict of interest.

96.5(3) *Approval process.* Applications shall be reviewed and recommended for approval or denial based on any or all of the following individual or collective criteria. Each applicable criterion shall be scored on a scale of zero to ten. Applicable scores shall be averaged. Nonapplicable criteria shall not be used in determining the average score. An application shall have a minimum average score of five to be eligible to be recommended for approval. If an application receives a score of zero on one or more applicable criteria, the application shall not be recommended for approval. A recommendation for approval by the task force does not constitute final approval of the application. The following categories on the application shall be evaluated and scored:

a. Infrastructure needs the project proposes to alleviate. Special consideration shall be given to infrastructure needs that relate to fire or health safety issues.

b. Evidence that remodeling, reconstructing, or repairing the existing buildings is not feasible.

c. Unavailability of alternative, less costly, or more effective means of serving student needs.

d. Improvement of transportation distance, convenience, cost and accessibility with the new construction.

e. Sustainable financial condition and long-term financial stability of the school district.

f. Evidence that the proposed project will improve educational opportunities for students and enable the school district to meet or exceed educational standards.

g. Current comprehensive, districtwide infrastructure plan and the description of how this project fits within that plan.

h. Description of collaboration with one or more other public or private entities.

96.5(4) *Ineligibility for approval.* If either of the following two descriptions applies to the school district, the school district shall not be eligible for a certificate of need unless a feasibility study conducted within the past three years pursuant to Iowa Code subsection 256.9(34) and the AEA plan pursuant to Iowa Code sections 275.1 to 275.4 determine that sharing, reorganization, or dissolution is not feasible for the school district.

a. If either the current enrollment or any of the five years of projected enrollments for the school district is fewer than 250 students.

b. If either the current enrollment or any of the five years of projected enrollments for the school district for grades 9 through 12 is fewer than a total of 100 students, if a high school building is the subject of the application.

96.5(5) *School budget review committee.* The SBRC shall review the recommendations from the task force for approval of certificates of need. The committee shall make recommendations on approval to the department for final consideration.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

281—96.6(423E,423F) Award process.

96.6(1) *Department determination.* The department shall make the final determination on approval of certificates of need.

96.6(2) *Notification.* The department shall notify applicants no later than two weeks following the date of receipt of the recommendations from the SBRC.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

281—96.7(423E,423F) Applicant responsibilities.

96.7(1) *Change in the project.* If a school district significantly changes the proposed project, the school district shall notify the department within ten working days of the change and shall submit a new application for a certificate of need for the newly changed project.

96.7(2) *Accounting for the funding.* All revenues from the local and statewide school infrastructure amounts and all expenditures from the local and statewide school infrastructure amounts shall be separately identified and accounted for in a capital projects fund established for the local option and statewide sales and services tax for school infrastructure proceeds.

96.7(3) *Withdrawal of application.* If a school district is granted a certificate of need for a project and the school district elects not to continue with the project, the school district shall notify the department within ten working days following the board action to discontinue the project.

96.7(4) *Forfeiture of certificate.* Failure to comply with any of the rules in this chapter or provide information that is included in the certificate of need application or that is requested by the department may result in the forfeiture of the certificate of need or removal from the application cycle.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

281—96.8(423E,423F) Appeal of certificate denial. Any applicant may appeal the denial of a properly submitted application for certificate of need to the director of the department. Appeals must be in writing and received within ten working days of the date of the notice of the decision to deny. Appeals must be based on a contention that the process was conducted outside of statutory authority; violated state or federal law, policy, or rule; did not provide adequate public notice; was altered without adequate public notice; or involved conflict of interest by staff or committee members. The hearing and appeals procedures found in 281—Chapter 6 that govern the director's decisions shall be applicable to any appeal of denial.

[ARC 8384B, IAB 12/16/09, effective 1/20/10]

These rules are intended to implement Iowa Code chapters 423E and 423F.

[Filed emergency 9/16/98—published 10/7/98, effective 9/16/98]

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[Filed ARC 9473B (Notice ARC 9373B, IAB 2/23/11), IAB 4/20/11, effective 5/25/11]

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]

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

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2) "a," "b," and "c."

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the Iowa Foundation for Medical Care or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)“a”(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment will not be approved for vaccines which are available through 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.

g. Payment will not be approved for injections of “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- (1) Correction of a congenital anomaly; or
- (2) Restoration of body form following an accidental injury; or
- (3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- (1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
- (2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.
- (3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- (4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

- (1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.
- (2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.
- (3) Augmentation mammoplasties.
- (4) Face lifts and other procedures related to the aging process.
- (5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.
- (6) Panniculectomy and body sculpture procedures.
- (7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.
- (8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.
- (9) Chemical peeling for facial wrinkles.
- (10) Dermabrasion of the face.
- (11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- (12) Removal of tattoos.
- (13) Hair transplants.
- (14) Electrolysis.
- (15) Sex reassignment.
- (16) Penile implant procedures.
- (17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

- (1) It is necessary for the physician to travel outside the home community, and
- (2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13) "e." On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

- (1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.
- (2) Sets work standards.
- (3) Establishes job description.
- (4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone.

Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs “*b*” through “*f*” shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual’s choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16) “*b*” shall be attached to the claim for payment and shall be signed by:

- (1) The person to be sterilized,
- (2) The interpreter, when one was necessary,
- (3) The physician, and
- (4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

- (1) In labor or childbirth, or
- (2) Seeking to obtain or obtaining an abortion, or
- (3) Under the influence of alcohol or other substance that affects the individual’s state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman’s life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross-reference 78.28(3))

78.1(19) Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review

applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1) "e.")

78.1(20) Transplants.

a. Payment will be made only for the following organ and tissue transplant services:

(1) Kidney, cornea, skin, and bone transplants.
(2) Allogeneic bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lymphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin's lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

(4) Liver transplants for persons with extrahepatic biliary artesia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:
 - A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
 - Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
 - Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) "f.")

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph “*a.*”

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term “physician” does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member’s pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the Current Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician’s supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

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

[ARC 8714B, IAB 5/5/10, effective 5/1/10]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for “covered outpatient drugs” as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

78.2(2) *Prescription required.* As a condition of payment for all drugs, including “nonprescription” or “over-the-counter” drugs that may otherwise be dispensed without a prescription, a prescription shall

be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used to cause anorexia, weight gain, or weight loss, except for lipase inhibitor drugs prescribed for weight loss with prior authorization as provided in paragraph “a.”

(3) Drugs used for cosmetic purposes or hair growth.

(4) Drugs used to promote smoking cessation, except for varenicline with prior authorization as provided in paragraph “a” above and generic, sustained-release bupropion products that are indicated for smoking cessation by the U.S. Food and Drug Administration.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer’s designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) “Covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any “Part D eligible individual” as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

78.2(5) *Nonprescription drugs.* The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 1250 mg (500 mg elemental calcium)
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml
Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
Magnesium oxide tablets 400 mg
Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
Miconazole nitrate cream 2% topical and vaginal
Miconazole nitrate vaginal suppositories, 100 mg
Multiple vitamin and mineral products with prior authorization

Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin liquid 1%
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
 Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
 Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
 Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
 Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
 Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
 Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder
 Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[ARC 8097B, IAB 9/9/09, effective 11/1/09; ARC 9175B, IAB 11/3/10, effective 1/1/11]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Foundation for Medical Care (IFMC). All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Readmissions to the same facility due to premature discharge shall

not be paid a new DRG. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross-reference 78.28(5)) The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)“b”(1) to (10) except for 78.2(4)“b”(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)“b”(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. Hospitals that wish to administer vaccines which are 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.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient’s condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient’s diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. Experience and survival rates.

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. Organ procurement. The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. Maintenance of data, research, review and evaluation.

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. Application procedure. A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. Review and approval of facilities. An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16) “a” and “r” to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual’s health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient’s medical condition including presenting symptoms and medical history prior to treatment or evaluation.

78.3(13) Payment for patients in acute hospital beds who are determined by IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(14) Payment for patients in acute hospital beds who are determined by IFMC to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor’s office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

78.3(16) Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine,

osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

78.4(1) Preventive services. Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of physical or mental disability, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once in a six-month period except for people who need more frequent applications because of physical or mental disability. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

78.4(2) Diagnostic services. Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panoramic-type radiography with bitewings is considered the same as a complete mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

78.4(3) Restorative services. Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2) "e")

e. Cast post and core, steel post and composite or amalgam in addition to a crown is payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a “four-surface” amalgam.

(9) An amalgam restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) Periodontal services. Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.28(2)“a”(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)“a”(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2)“a”(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2)“a”(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

78.4(5) Endodontic services. Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment is payable when prior approval has been received. Payment for an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.28(2) "d")

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.4(6) Oral surgery—medically necessary. Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.

j. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

k. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) Prosthetic services. Payment may be made for the following prosthetic services:

a. An immediate denture and a first-time complete denture including six months' postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months' postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2) "c"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2) "c"(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2) "c"(3))

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

i. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

j. Two repairs per prosthesis in a 12-month period are payable.

k. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

l. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. When prior approval has been given for orthodontic services to treat the most handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of

the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)“d”)

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) Treatment in a hospital. Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

78.4(11) Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or exams are not billed for that visit.

78.4(12) Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

78.4(13) Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

78.4(14) Services to members 21 years of age or older. Orthodontic procedures are not covered for members 21 years of age or older.

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

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

- a.* Durable plantar foot orthotic.
- b.* Plaster impressions for foot orthotic.
- c.* Molded digital orthotic.
- d.* Shoe padding when appliances are not practical.
- e.* Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.
- f.* Rams horn (hypertrophic) nails.
- g.* Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

- a.* Treatment of flatfoot. The term “flatfoot” is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)“c.” Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist’s office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist’s office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended

ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation.

d. Single vision and multifocal lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.

2. Verification of lenses after fabrication.

3. Adjustment and alignment of completed lens order.

(2) New lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.

2. Up to four times per year for children one through three years of age.

3. Once every 12 months for children four through seven years of age.

4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Protective lenses are allowed for:

1. Children through seven years of age.

2. Members with vision in only one eye.

3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.

2. Sizing and measurements.

3. Fitting and adjustment.

4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.

2. One frame every 12 months is allowed for children four through six years of age.

3. When there is a prescribed lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.

2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

- a. Corrected curve lenses, unless clinically contraindicated, manufactured by reputable American manufacturers.
- b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.
- c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice.

a. Materials payable by fee schedule are:

- (1) Lenses, single vision and multifocal.
- (2) Frames.
- (3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

- (1) Contact lenses.
- (2) Schroeder shield.
- (3) Ptosis crutch.
- (4) Protective lenses and safety frames.
- (5) Subnormal visual aids.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

(Cross-reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

- a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.
- b. Glasses for protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3) "b"(4).
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1) "i."

78.6(6) *Therapeutically certified optometrists.* Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross-reference 78.28(3))

78.7(1) to 78.7(3) Rescinded IAB 4/3/02, effective 6/1/02.

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

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) Covered services. Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) Indications and limitations of coverage.

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of “pain” is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient’s condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		

ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	723.5 Torticollis, unspecified	
	724.01 Spinal stenosis, thoracic region	
	724.02 Spinal stenosis, lumbar region	
	724.4 Thoracic or lumbosacral neuritis or radiculitis	
	724.6 Disorders of sacrum, ankylosis	
	724.79 Disorders of coccyx, coccygodynia	
	724.8 Other symptoms referable to back, facet syndrome	
	729.1 Myalgia and myositis, unspecified	
	729.4 Fascitis, unspecified	
	738.40 Acquired spondylolisthesis	
	756.12 Spondylolisthesis	
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint, ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

b. The neuromusculoskeletal conditions listed in the table in paragraph “*a*” generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

- (1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) Documenting X-ray. An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph "c" of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph "a" of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph "a" of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

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

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10) "a" may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of

supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 62 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- a. Place of service.
- b. Type of service to be rendered and the treatment modalities being used.
- c. Frequency of the services.
- d. Assistance devices to be used.
- e. Date home health services were initiated.
- f. Progress of member in response to treatment.
- g. Medical supplies to be furnished.
- h. Member's medical condition as reflected by the following information, if applicable:
 - (1) Dates of prior hospitalization.
 - (2) Dates of prior surgery.
 - (3) Date last seen by a physician.
 - (4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 - (5) Prognosis.
 - (6) Functional limitations.
 - (7) Vital signs reading.
 - (8) Date of last episode of instability.
 - (9) Date of last episode of acute recurrence of illness or symptoms.
 - (10) Medications.
- i. Discipline of the person providing the service.
- j. Certification period (no more than 62 days).
- k. Estimated date of discharge from the hospital or home health agency services, if applicable.
- l. Physician's signature and date. The plan of care must be signed and dated by the physician

before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per

week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "b."

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "c."

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs "a" and "d."

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) Medical social services.

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

- (1) Are reasonable and necessary to the treatment of a member's illness or injury.
- (2) Contribute meaningfully to the treatment of the member's condition.
- (3) Are under the direction of a physician.
- (4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.
- (5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

78.9(9) Home health agency care for maternity patients and children. The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

- (1) The potential risk factors,
- (2) The medical factor or symptom which verifies the child is at risk,
- (3) The reason the member is unable to obtain care outside of the home,
- (4) The medically related task of the home health agency,
- (5) The member's diagnosis,
- (6) Specific services and goals, and
- (7) The medical necessity for the services to be rendered. A single high-risk factor does not provide

sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

- (1) Aged 16 or under.
- (2) First pregnancy for a woman aged 35 or over.
- (3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.
- (4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.
- (5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.
- (6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.
- (7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to mental retardation.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Mental retardation or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) Private duty nursing or personal care services for persons aged 20 and under. Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.
4. Services requiring prior authorization that are provided without regard to the prior authorization process.
5. Transportation services.
6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services

to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.28(9))

78.9(11) Vaccines. Home health agencies which wish to administer vaccines which are 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. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 9315B, IAB 12/29/10, effective 2/2/11]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) General payment requirements. Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

- (1) Physical fitness equipment, e.g., an exercycle, weights.
- (2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.
- (3) Self-help devices, e.g., safety grab bars, raised toilet seats.
- (4) Training equipment, e.g., speech teaching machines, braille training texts.
- (5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions, or is primarily for the convenience of a person caring for the patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise, and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators will be maintained on a rental basis for the duration of use.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

78.10(2) Durable medical equipment. DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.
Automated medication dispenser. See 78.10(2) “d” for prior authorization requirements.
Bedpan.
Blood glucose monitors, subject to the limitation in 78.10(2) “e.”
Blood pressure cuffs.
Cane.
Cardiorespiratory monitor (rental and supplies).
Commode.
Commode pail.
Crutches.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2) “d” for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2) “d” for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2) “a” and 78.10(2) “c.”
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2) “d” for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician’s, physician assistant’s, or advanced registered nurse practitioner’s prescription shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician’s Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;

2. The oxygen flow rate and concentration;
3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(2) If the patient's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

(5) All accessories, disposable supplies, servicing, and repairing of concentrators are included in the monthly Medicaid payment for concentrators.

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

2. The patient's mobility puts the patient at risk for injury.

3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient with a diagnosis of a lung disorder if all of the following conditions are met:

1. Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease of lung function.

2. The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

3. Treatment by flutter device failed or is contraindicated.

4. Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

5. All other less costly alternatives have been tried.

(4) Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

1. The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

2. The member is on two or more medications prescribed to be administered more than one time a day.

3. The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

4. Less costly alternatives, such as medisets or telephone reminders, have failed.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

- (1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

78.10(3) Prosthetic devices. Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a patient prior to the time the patient undergoes a procedure which will make necessary the use of the device.

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3) "c" for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3) "c" for prior approval requirements.

(5) Hearing aids. See rule 441—78.14(249A).

(6) Oral nutritional products. See 78.10(3) "c" for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3) "d" for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross-reference 78.28(4))

c. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1) "c")

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.
2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.
3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member's condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.
2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.
3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

- (1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or
- (2) The member is between 6 and 18 months of age and there is documentation of either of the following conditions:
 1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or
 2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) Medical supplies. Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent

cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic blood glucose test strips, subject to the limitation in 78.10(4) "c."

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

Diabetic supplies (needles and syringes, blood glucose test strips and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 8993B, IAB 8/11/10, effective 10/1/10; ARC 9256B, IAB 12/1/10, effective 1/1/11]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient's condition and the recipient is transported to the nearest hospital with appropriate

facilities or to one in the same locality, from one hospital to another, to the patient's home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

- a. The individual is admitted as a hospital inpatient or in an emergency situation.
- b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

- One patient - normal allowance
- Two patients - 3/4 normal allowance per patient
- Three patients - 2/3 normal allowance per patient
- Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)“j.”

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) Covered services. Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

- (5) Community psychiatric supportive treatment is not intended to be provided in a group.
- b.* Crisis intervention to de-escalate situations in which a risk to self, others, or property exists.
- (1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.
- (2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.
- c.* Health or behavior intervention, used to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.
- (1) Interventions may address the following skills for effective functioning with family, peers, and community: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.
- (2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.
- (3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.
- d.* Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.
- (1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.
- (2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.
- e.* Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.
- (1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.
- (2) Skills training and development services are covered only for Medicaid members aged 18 or over.
- 78.12(2) Excluded services.** Services that are habilitative in nature are not covered as remedial services. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.
- 78.12(3) Coverage requirements.** Medicaid covers remedial services only when the following conditions are met:
- a.* A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:
- (1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and
- (2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).
- b.* The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

- c.* For a member under the age of 21, the licensed practitioner of the healing arts:
- (1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;
 - (2) Has completed an initial formal assessment of the member using the instrument selected; and
 - (3) Completes a formal assessment using the same instrument every six months thereafter if continued services are ordered.

d. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

- (1) The member or the member's parent or guardian; and
- (2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) *Approval of plan.* The remedial services provider shall submit the treatment plan, the results of the formal assessment, and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial plan. The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

- (1) The plan conforms to the medical necessity requirements in subrule 78.12(3);
- (2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;
- (3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
- (4) The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);
- (5) The plan does not exceed six months' duration; and
- (6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. Subsequent plans. The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph "a" if the services are recommended by a licensed practitioner of the healing arts who has:

- (1) Reexamined the member;
 - (2) Reviewed the original diagnosis and treatment plan;
 - (3) Evaluated the member's progress, including a formal assessment as required by 78.12(3) "c"(3);
- and
- (4) Submitted the results of the formal assessment with the recommendation for continued services.

c. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

- (1) The time elapsed from referral to remedial plan development;
- (2) The continuity of treatment;
- (3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;
- (4) Gaps in service;
- (5) The results achieved; and
- (6) Member satisfaction.

78.12(5) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of remedial services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

- a.* Consistent with the diagnosis and treatment of the member's condition;
- b.* Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;
- c.* The least costly type of service that can reasonably meet the medical needs of the member; and
- d.* In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

- (1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

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

[ARC 8504B, IAB 2/10/10, effective 3/22/10]

441—78.13(249A) Nonemergency medical transportation. Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

78.13(1) Member request. When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

78.13(2) Necessary services. Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

78.13(3) Access to free transportation. Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

78.13(4) Closest medical provider. Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

a. The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

b. The additional cost of transportation to the provider requested by the member is medically justified based on:

- (1) A previous relationship between the member and the requested provider,
- (2) Prior experience of the member with closer providers, or
- (3) Special expertise or experience of the requested provider.

78.13(5) Coverage. Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

a. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

b. The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

c. When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

d. The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

78.13(6) Exceptions for nursing facility residents.

a. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

b. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

78.13(7) Grievances. Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.” For transportation providers, the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) Physician examination. The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member’s best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) Audiological testings. A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) Hearing aid evaluation. A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) Hearing aid selection. A physician or audiologist may recommend a specific brand or model appropriate to the member’s condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member’s condition.

78.14(5) Travel. When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member’s place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) Purchase of hearing aid. The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

- a. A child needs the aid for speech development,
- b. The aid is needed for educational or vocational purposes,
- c. The aid is for a blind member,
- d. The member’s hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or
- e. Lack of binaural amplification poses a hazard to a member’s safety.

78.14(7) Payment for hearing aids.

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist’s fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer’s depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer’s invoice. Payment shall

be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)“a.”

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross-reference 78.28(4)“a”)

(2) Payment for a hearing aid costing more than \$650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross-reference 78.28(4)“b”):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8008B, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) Definitions.

“*Custom-molded shoe*” means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;
2. Is made of leather or another suitable material of equal quality;
3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and
4. Has some form of closure.

“*Depth shoe*” means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;
2. Is made from leather or another suitable material of equal quality;
3. Has some form of closure; and
4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

“*Insert*” means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) Prescription. The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

- (1) The reasons the recipient cannot be fitted with a depth shoe.
- (2) Pain.
- (3) Tissue breakdown or a high probability of tissue breakdown.
- (4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)“*b*” with the following exceptions:

- (1) Services by staff psychiatrists, or
- (2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or
- (3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients’ treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)“*b*”(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)“*b*”(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6) "b."

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs “c” to “h” below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor’s degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient’s case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. Program services. Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with

appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. Discharge criteria. Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. Coordination of services. Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. Stable milieu. The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. Chronic mental illness. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

- (1) Six screenings in the first year of life.
- (2) Four screenings between the ages of 1 and 2.
- (3) One screening a year at ages 3, 4, 5, and 6.
- (4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

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

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. General provisions regarding coverage of services.

(1) Services are provided in the recipient's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who

requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)“b”(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient’s specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)“b”(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient’s rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)“b”(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person’s illness, injury, or disabling condition, be specific and effective treatment for the patient’s medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient’s condition in a reasonable amount of time based on the patient’s restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient’s injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient’s medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient’s level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential.

Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

- (1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required

for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1) "b"(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1) "b"(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)“b”(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number “5” under 78.19(1)“b”(16) will not apply to trial therapy.

78.19(2) General guidelines for plans of treatment.

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient’s current medical condition and functional abilities, including any disabling condition.

(2) The physician’s signature and date (within the certification period).

(3) Certification period.

(4) Patient’s progress in measurable statistics. (Refer to 78.19(1)“b”(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient’s prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient’s rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

(5) The date of the start of the services.

(6) The frequency of the services.

(7) Progress in response to the services.

(8) The estimated length of time the services are needed.

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

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians’ offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) Vaccines. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) Sterilization. Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) Vaccines. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

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

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

78.25(1) Provider qualifications.

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) Services covered for all pregnant women. Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)“b.”

78.25(3) Enhanced services covered for women with high-risk pregnancies. Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

- (2) Ongoing nutritional assessment.
 - (3) Development of an individualized nutritional care plan.
 - (4) Referral to food assistance programs if indicated.
 - (5) Nutritional intervention.
 - d.* Psychosocial assessment and counseling, which shall include:
 - (1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
 - (2) A profile of the client's family composition, patterns of functioning and support systems.
 - (3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.
 - e.* A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:
 - (1) Assessment of mother's health status.
 - (2) Physical and emotional changes postpartum.
 - (3) Family planning.
 - (4) Parenting skills.
 - (5) Assessment of infant health.
 - (6) Infant care.
 - (7) Grief support for unhealthy outcome.
 - (8) Parenting of a preterm infant.
 - (9) Identification of and referral to community resources as needed.
- This rule is intended to implement Iowa Code section 249A.4.

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

- a.* Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;
- b.* Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and
- c.* Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

- a.* Abortion procedures are covered only when criteria in subrule 78.1(17) are met.
- b.* Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.
- c.* Preprocedure review by the Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth

under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (Cross-reference 78.28(6))

This rule is intended to implement Iowa Code section 249A.4.
[ARC 8205B, IAB 10/7/09, effective 11/11/09]

441—78.27(249A) Home- and community-based habilitation services.

78.27(1) Definitions.

“*Adult*” means a person who is 18 years of age or older.

“*Assessment*” means the review of the current functioning of the member using the service in regard to the member’s situation, needs, strengths, abilities, desires, and goals.

“*Case management*” means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

“*Comprehensive service plan*” means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

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

“*Emergency*” means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

“*HCBS*” means home- and community-based services.

“*Interdisciplinary team*” means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member’s need for services.

“*ISIS*” means the department’s individualized services information system.

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

“*Program*” means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

78.27(2) Member eligibility. To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. Risk factors. The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member’s life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member’s Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The member’s case manager has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department approval of a member's eligibility for the program cannot be reimbursed.

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) Application for services. The case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager shall establish an interdisciplinary team for the member. The team shall include the case manager and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial service plan and annual updates to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written case plan must be completed, signed and dated by the case manager or service worker within 30 calendar days after plan approval.

(10) Any changes to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before the implementation of services. Services provided before the approval date are not payable.

b. Service goals and activities. The comprehensive service plan shall:

- (1) Identify observable or measurable individual goals.
- (2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.
- (3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.
- (4) List all Medicaid and non-Medicaid services received by the member and identify:
 1. The name of the provider responsible for delivering the service;
 2. The funding source for the service; and
 3. The number of units of service to be received by the member.
- (5) Identify for a member receiving home-based habilitation:
 1. The member's living environment at the time of enrollment;
 2. The number of hours per day of on-site staff supervision needed by the member; and
 3. The number of other members who will live with the member in the living unit.
- (6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. Rights restrictions. Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan shall include documentation of:

- (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;
- (2) The need for the restriction; and
- (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. Emergency plan. The comprehensive service plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

- (1) The member's interdisciplinary team shall identify in the comprehensive service plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.
- (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.
- (3) Providers of applicable services shall provide for emergency backup staff.

e. Plan approval. Services shall be entered into ISIS based on the comprehensive service plan. A service plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) "e."

78.27(5) Requirements for services. Home- and community-based habilitation services shall be provided in accordance with the following requirements:

- a.* The services shall be based on the member's needs as identified in the member's comprehensive service plan.
- b.* The services shall be delivered in the least restrictive environment appropriate to the needs of the member.
- c.* The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.
- d.* Service components that are the same or similar shall not be provided simultaneously.
- e.* Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.
- f.* Reimbursement is not available for room and board.
- g.* Services shall be billed in whole units.
- h.* Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) Case management. Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) Home-based habilitation. “Home-based habilitation” means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. Scope. Home-based habilitation services are individualized supportive services provided in the member’s home and community that assist the member to reside in the most integrated setting appropriate to the member’s needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member’s comprehensive service plan. Covered supports include:

- (1) Adaptive skill development;
- (2) Assistance with activities of daily living;
- (3) Community inclusion;
- (4) Transportation;
- (5) Adult educational supports;
- (6) Social and leisure skill development;
- (7) Personal care; and
- (8) Protective oversight and supervision.

b. Exclusions. Home-based habilitation payment shall not be made for the following:

- (1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.
- (2) Service activities associated with vocational services, day care, medical services, or case management.
- (3) Transportation to and from a day program.
- (4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.
- (5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or “bundled” service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) Day habilitation. “Day habilitation” means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. Scope. Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member’s maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member’s:

- (1) Intellectual functioning;
- (2) Physical and emotional health and development;
- (3) Language and communication development;
- (4) Cognitive functioning;
- (5) Socialization and community integration;
- (6) Functional skill development;
- (7) Behavior management;
- (8) Responsibility and self-direction;
- (9) Daily living activities;

- (10) Self-advocacy skills; or
- (11) Mobility.

b. Setting. Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. Duration. Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. Exclusions. Day habilitation payment shall not be made for the following:

- (1) Vocational or prevocational services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational habilitation.* "Prevocational habilitation" means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member's comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

- (1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation services.
- (2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.
- (3) Compensation to members for participating in prevocational services.

78.27(10) *Supported employment habilitation.* "Supported employment habilitation" means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

(1) Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a member for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the member and the interdisciplinary team described in subrule 78.27(4) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the member's interdisciplinary team must determine that the identified services are necessary. Third, the Iowa Medicaid enterprise medical services unit must approve the services. Available components of activities to obtain a job are as follows:

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A member

may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member's customized training plan.

3. Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the member for a minimum of 30 days or with assisting the member in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the member's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include: job opening identification with the member; assistance with applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or "enclave" setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member's job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) *Adverse service actions.*

a. Denial. Services shall be denied when the department determines that:

(1) Rescinded IAB 12/29/10, effective 1/1/11.

(2) The member is not eligible for or in need of home- and community-based habilitation services.

(3) The service is not identified in the member's comprehensive service plan.

(4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) Completion or receipt of required documents for the program has not occurred.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially

changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

d. Appeal rights. The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

78.27(12) County reimbursement. The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); ARC 9311B, IAB 12/29/10, effective 1/1/11; ARC 9403B, IAB 3/9/11, effective 5/1/11]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. (Cross-reference 78.10(2) "b") Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time a day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition. (Cross-reference 78.10(3) "c"(2))

(1) A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical

necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3) "c"(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department's consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and on the published criteria established by the department and the IFMC. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices.

The "Preprocedure Surgical Review List" shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2) "c") The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross-reference 78.10(2) "c")

i. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)“*c*”) The department shall approve payment for oral nutritional products when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member’s condition.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member’s total medical condition that includes a description of the member’s metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member’s nutritional status and indicate that the member’s nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)“*c*”) The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4)“*b*”)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4)“*c*”)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4)“*d*”)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy

may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4)“e”)

b. Surgical endodontic treatment which includes an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue will be approved when nonsurgical treatment has been attempted and a reasonable time has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross-reference 78.4(5)“c”)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion or the member has a full denture in one arch, and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7)“c”)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)“d”)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7)“e”)

(4) Dental implants and related services will be authorized when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

d. Orthodontic services will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J. A. Salzman, D.D.S., American Journal of Orthodontics, October 1968.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;

5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department's orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8) "a")

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3) "d")

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross-references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross-reference 78.14(7) "d"(1))

b. A hearing aid costing more than \$650. The department shall approve payment for either of the following purposes (Cross-reference 78.14(7) "d"(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross-reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

c. Preprocedure review by the IFMC is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the criteria established by the department and IFMC. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

b. Preprocedure review by the IFMC is required if ambulatory surgical centers are to be reimbursed for surgical procedures as set forth in subrule 78.1(19). Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and criteria established by the IFMC and the department. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

78.28(8) Rescinded IAB 1/3/96, effective 3/1/96.

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.
2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.
3. Services provided to other persons in the member's household.

4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross-reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross-reference 78.10(3) "b")

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09; ARC 8714B, IAB 5/5/10, effective 5/1/10; ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, or master social worker within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) Limitations.

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) Exclusions. Payment will not be approved for the following services:

- a. Services provided in a medical institution.
- b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.
- c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.
- d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) Payment.

- a. Payment shall be made only for time spent in face-to-face consultation with the member.
- b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

- a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.
- b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) Vaccines. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

441—78.31(249A) Hospital outpatient services.

78.31(1) Covered hospital outpatient services. Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs "g" to "m" are subject to a random sample retrospective review for medical necessity by the Iowa Foundation for Medical Care. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs "a" to "f" shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs "g" to "m" shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

- a. Emergency service.
- b. Outpatient surgery.
- c. Laboratory, X-ray and other diagnostic services.
- d. General or family medicine.
- e. Follow-up or after-care specialty clinics.
- f. Physical medicine and rehabilitation.
- g. Alcoholism and substance abuse.
- h. Eating disorders.
- i. Cardiac rehabilitation.
- j. Mental health.
- k. Pain management.
- l. Diabetic education.
- m. Pulmonary rehabilitation.

n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. Need for service. It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. Professional direction. All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. Goals and objectives. The goals and objectives of the program must be clearly stated. Paragraphs “*d*” and “*f*” and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. Treatment modalities used. The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. Criteria for selection and continuing treatment of patients. The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. Length of program. There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. Monitoring of services. The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. Hospital outpatient programs that wish to administer vaccines which are 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. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs “*g*” to “*m*,” must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff’s relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) Requirements for specific types of service.*a. Alcoholism and substance abuse.*

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa, bulimia, or bulimarexia. Compulsive overeaters are not acceptable for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.
Any suicidal thoughts or attempts.
Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.
History of experiencing physical or sexual (incest or rape) abuse.
History of other counseling experiences.
Appropriate psychological assessment, including psychological orientation to the above questions.
A medical history, including a physical examination, covering the information listed in subparagraph (4) below.
Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.
The patient's social support networks, including family and peer relationships.
The patient's educational level, vocational status, and job or school performance history, as appropriate.
The patient's leisure, recreational, or vocational interests and hobbies.
The patient's ability to participate with peers and programs and social activities.
Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.
Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

- Referral form.
- Physician's orders.
- Laboratory reports.
- Electrocardiogram reports.
- History and physical examination.
- Angiogram report, if applicable.
- Operative report, if applicable.
- Preadmission interview.
- Exercise prescription.
- Rehabilitation plan, including participant's goals.
- Documentation for exercise sessions and progress notes.
- Nurse's progress reports.
- Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the

effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day. Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to

self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS intellectual disability waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

[ARC 9403B, IAB 3/9/11, effective 5/1/11]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) Homemaker services. Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. Meal preparation planning and preparing balanced meals.

78.34(2) Home health services. Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.34(4) Nursing care services. Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

78.34(5) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be

used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in rule 441—83.1(249A).

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician.

The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (1) Tube feedings of members unable to eat solid foods.
 - (2) Intravenous therapy administered by a registered nurse.
 - (3) Parenteral injections required more than once a week.
 - (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
 - (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
 - (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
 - (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
 - (8) Colostomy care.
 - (9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.
 - (10) Postsurgical nursing care.
 - (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
 - (12) Preparing and monitoring response to therapeutic diets.
 - (13) Recording and reporting of changes in vital signs to the nurse or therapist.
- c.* A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.
- d.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.
- e.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.
- f.* The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.
- g.* The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.
- h.* If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.
- i.* If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.
- j.* The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.34(8) Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be 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 service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 one-hour units of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.
- (3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.
- (4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.
- (5) The member-to-staff ratio shall not be more than six members to one staff person.
- (6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.34(9) Home and vehicle modification. Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

(1) Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized

in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS ill and handicapped waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13) "b"(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13) "b"(2) or the utilization adjustment factor in subparagraph 78.34(13) "b"(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.

2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.

3. Be accommodated within the member's budget without compromising the member's health and safety.

4. Be provided to the member or directed exclusively toward the benefit of the member.

5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.

2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13) "d." The savings plan shall meet the requirements in paragraph 78.34(13) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.
- (8) Assist the member in completing required federal, state, and local tax and insurance forms.
- (9) Establish and manage documents and files for the member and the member's employees.
- (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.
- (11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.
- (12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.
- (13) Establish a customer services complaint reporting system.
- (14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.
- (15) Develop a business continuity plan in the case of emergencies and natural disasters.
- (16) Provide to the department an annual independent audit of the financial management service.
- (17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter)]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) General characteristics. A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

- (1) Nursing care.
- (2) Medical social services.
- (3) Physician services.
- (4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.
- (5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.
- (6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

- (7) Homemaker and home health aide services.
- (8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.
- (9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their

life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

78.37(1) Adult day care services. Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.37(2) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) Homemaker services. Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, and washing and mending clothes.

c. Accompaniment to medical or psychiatric services.

d. Meal preparation: planning and preparing balanced meals.

e. Bathing and dressing for self-directing recipients.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

78.37(6) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) Home and vehicle modification. Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is one hour.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed

nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (1) Tube feedings of members unable to eat solid foods.
- (2) Intravenous therapy administered by a registered nurse.
- (3) Parenteral injections required more than once a week.
- (4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.
- (5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.
- (6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.
- (7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- (8) Colostomy care.
- (9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.
- (10) Postsurgical nursing care.
- (11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.
- (12) Preparing and monitoring response to therapeutic diets.
- (13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.37(16) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16) "b"(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16) "b"(2) or the utilization adjustment factor in subparagraph 78.37(16) "b"(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before

becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.

10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)“d.” The savings plan shall meet the requirements in paragraph 78.37(16)“f.”

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
 2. Be medically necessary, and
 3. Be approved by the member's case manager or service worker.
- (4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.
(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.
(4) Authorize payment for optional service components identified in the individual budget.
(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.
(2) The representative shall not be a current provider of service to the member.
(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) Case management services. Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate

services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) Home health aide services. Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

- a.* Observation and reporting of physical or emotional needs.
- b.* Helping a client with bath, shampoo, or oral hygiene.
- c.* Helping a client with toileting.
- d.* Helping a client in and out of bed and with ambulation.
- e.* Helping a client reestablish activities of daily living.
- f.* Assisting with oral medications ordinarily self-administered and ordered by a physician.
- g.* Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) Homemaker services. Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

- a.* Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.
- b.* Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the client, and dishes.
- c.* Accompaniment to medical or psychiatric services or for children aged 18 and under to school.
- d.* Meal preparation: planning and preparing balanced meals.

78.38(4) Nursing care services. Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury

and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

78.38(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

f. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

g. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

h. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.38(9) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)“b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)“b”(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member’s needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9) "d." The savings plan shall meet the requirements in paragraph 78.38(9) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter)]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) Vaccines. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) Direct payment. Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) Location of service. Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) Vaccine administration. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

78.40(5) Prenatal risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the member in achieving the member's life goals. The services, amount and supports provided under the HCBS intellectual disability waiver shall be delivered in the least restrictive environment and in conformity with the member's service plan. Reimbursement shall not be available under the waiver for any services that the member can obtain through the Medicaid state plan. All services shall be billed in whole units.

78.41(1) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph 78.41(1)"f"(1) does not apply.

g. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year when 366 daily units are available.

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

78.41(2) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed \$7,050 per the member's waiver year.

e. The service shall be identified in the member's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

g. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

j. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically

included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.
- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A).

Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

- a. Services shall be included in the member's service plan.
- b. A unit is one hour.
- c. A maximum of 14 units are available per week.

78.41(7) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs "a" and "b" that address the disability-related challenges to securing and keeping a job.

a. *Activities to obtain a job.* Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The

interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.
3. Work site assessment and job accommodation evaluation.
- b. Supports to maintain employment.
 - (1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:
 1. Individual work-related behavioral management.
 2. Job coaching.
 3. On-the-job or work-related crisis intervention.
 4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
 5. Consumer-directed attendant care services as defined in subrule 78.41(8).
 6. Assistance with time management.
 7. Assistance with appropriate grooming.
 8. Employment-related supportive contacts.
 9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
 10. On-site vocational assessment after employment.
 11. Employer consultation.
 - (2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or "enclave" setting.
 - (3) A unit of service is one hour.
 - (4) A maximum of 40 units may be received per week.
- c. The following requirements apply to all supported employment services:
 - (1) Employment-related adaptations required to assist the consumer within the performance of the consumer's job functions shall be provided by the provider as part of the services.
 - (2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.
 - (3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.
 - (4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.
 - (5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.
 - (6) All services shall be identified in the consumer's service plan maintained pursuant to rule 441—83.67(249A).
 - (7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be 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 service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 one-hour units of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and

that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)“*d.*”

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.41(14) *Day habilitation services.*

a. Scope. Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer's intellectual functioning, physical and emotional health and development, language

and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

b. Family training option. Day habilitation services may include training families in treatment and support methodologies or in the care and use of equipment. Family training may be provided in the consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. Unit of service. Except as provided in paragraph "b," the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)"b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15) “b”(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15) “b”(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15) “b”(2) or the utilization adjustment factor in subparagraph 78.41(15) “b”(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member’s service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member’s needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15) “d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)"d." The savings plan shall meet the requirements in paragraph 78.41(15)"f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed

personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

- (1) Contract with entities to provide services and supports as described in this subrule.
- (2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).
- (3) Schedule the provision of services.
- (4) Authorize payment for optional service components identified in the individual budget.
- (5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

- (1) The representative must be at least 18 years old.
- (2) The representative shall not be a current provider of service to the member.
- (3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
- (4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter)]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the vaccines for children program administered by the department of public health if the pharmacy is enrolled in the vaccines for children program. No payment will be made for the vaccine.

[ARC 9132B, IAB 10/6/10, effective 11/1/10; ARC 9316B, IAB 12/29/10, effective 2/2/11]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

78.43(1) Case management services. Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

78.43(2) Supported community living services. Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan.

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work or day programs.

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

b. The supported community living services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. Activities do not include those associated with vocational services, academics, day care, medical services, Medicaid case management or other case management. Services are individualized supportive services provided in a variety of community-based, integrated settings.

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to members for whom a daily rate is not established.

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed \$1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph 78.43(2) "e"(1) does not apply.

f. The maximum number of units available per member is as follows:

(1) 365 daily units per state fiscal year except a leap year, when 366 daily units are available.

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly units are available.

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

78.43(3) Respite care services. Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

h. Respite services provided for a period exceeding 24 consecutive hours to three or more individuals who require nursing care because of a mental or physical condition must be provided by a health care facility licensed as described in Iowa Code chapter 135C.

78.43(4) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs "a" and "b" that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or rehabilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet

the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.

2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.

3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.

2. Job analysis for a specific job.

3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.

4. Identifying and arranging reasonable accommodations with the employer.

5. Providing disability awareness and training to the employer when it is deemed necessary.

6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

(3) Enhanced job search activities. Enhanced job search activities are associated with obtaining initial employment after job development services have been provided to the consumer for a minimum of 30 days or with assisting the consumer in changing jobs due to layoff, termination, or personal choice. The interdisciplinary team must review and update the Iowa vocational rehabilitation services supported employment readiness analysis form to determine if this service remains appropriate for the consumer's employment goals. A unit of service is an hour. A maximum of 26 units may be provided in a 12-month period. The services provided may include:

1. Job opening identification with the consumer.

2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.

b. Supports to maintain employment.

(1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:

1. Individual work-related behavioral management.

2. Job coaching.

3. On-the-job or work-related crisis intervention.

4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.

5. Consumer-directed attendant care services as defined in subrule 78.43(13).

6. Assistance with time management.

7. Assistance with appropriate grooming.

8. Employment-related supportive contacts.
 9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
 10. On-site vocational assessment after employment.
 11. Employer consultation.
 - (2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.
 - (3) A unit of service is one hour.
 - (4) A maximum of 40 units may be received per week.
 - c. The following requirements apply to all supported employment services:
 - (1) Employment-related adaptations required to assist the consumer within the performance of the consumer’s job functions shall be provided by the provider as part of the services.
 - (2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.
 - (3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.
 - (4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.
 - (5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.
 - (6) All services shall be identified in the consumer’s service plan maintained pursuant to rule 441—83.67(249A).
 - (7) The following services are not covered:
 1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
 2. Supports for volunteer work or unpaid internships;
 3. Tuition for education or vocational training; or
 4. Individual advocacy that is not consumer specific.
 - (8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.
- 78.43(5) Home and vehicle modification.** Covered home and vehicle modifications are physical modifications to the member’s home or vehicle that directly address the member’s medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.
 - a. Modifications that are necessary or desirable without regard to the member’s medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.
 - b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
 - (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
 - (3) Grab bars and handrails.
 - (4) Turnaround space adaptations.
 - (5) Ramps, lifts, and door, hall and window widening.
 - (6) Fire safety alarm equipment specific for disability.
 - (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
 - (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
 - (9) Keyless entry systems.
 - (10) Automatic opening device for home or vehicle door.
 - (11) Special door and window locks.
 - (12) Specialized doorknobs and handles.
 - (13) Plexiglas replacement for glass windows.
 - (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
 - (15) Motion detectors.
 - (16) Low-pile carpeting or slip-resistant flooring.
 - (17) Telecommunications device for the deaf.
 - (18) Exterior hard-surface pathways.
 - (19) New door opening.
 - (20) Pocket doors.
 - (21) Installation or relocation of controls, outlets, switches.
 - (22) Air conditioning and air filtering if medically necessary.
 - (23) Heightening of existing garage door opening to accommodate modified van.
 - (24) Bath chairs.
- c. A unit of service is the completion of needed modifications or adaptations.
- d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.
- e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.
- f. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.
- g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.
- h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) Personal emergency response or portable locator system.

- a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.
- (1) The necessary components of a system are:
 1. An in-home medical communications transceiver.
 2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.
 4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

c. A unit of service is a full day (4 to 8 hours), a half day (1 to 4 hours), or an hour.

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

78.43(14) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be 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 service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

- (1) To allow the member's usual caregivers to be employed,
- (2) During a search for employment by a usual caregiver,
- (3) To allow for academic or vocational training of a usual caregiver,
- (4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or
- (5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

- (1) Provide experiences for each member's social, emotional, intellectual, and physical development;
- (2) Include comprehensive developmental care and any special services for a member with special needs; and
- (3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

- (1) A maximum of 12 one-hour units of service is available per day.
- (2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is one hour.

78.43(15) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15) "b"(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)“b”(2) or the utilization adjustment factor in subparagraph 78.43(15)“b”(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member’s service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member’s home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member’s service plan developed by the member’s case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member’s service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member’s budget without compromising the member’s health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member’s needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member’s individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)“d.” Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)"d." The savings plan shall meet the requirements in paragraph 78.43(15)"f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.
(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.
(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.
(4) Authorize payment for optional service components identified in the individual budget.
(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.
(2) The representative shall not be a current provider of service to the member.
(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.
(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

- (1) Recruit employees.
- (2) Select employees from a worker registry.
- (3) Verify employee qualifications.
- (4) Specify additional employee qualifications.
- (5) Determine employee duties.
- (6) Determine employee wages and benefits.
- (7) Schedule employees.
- (8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[ARC 7957B, IAB 7/15/09, effective 7/1/09; ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter)]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) Applicability. ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.
b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

- (1) Treatment objectives and outcomes,
- (2) The expected frequency and duration of each service,
- (3) The location where the services will be provided,
- (4) A crisis plan, and
- (5) The schedule for updates of the treatment plan.

78.45(2) Services. The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. *Evaluation and medication management.*

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. *Integrated therapy and counseling for mental health and substance abuse.* This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. *Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. Crisis response. Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. Work-related services. Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[ARC 9440B, IAB 4/6/11, effective 4/1/11]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

78.46(1) Consumer-directed attendant care service. Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

a. Providers must demonstrate proficiency in delivery of the services in the member's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training.

(1) All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan.

(2) The member shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the member.

b. Nonskilled service activities covered are:

(1) Help with dressing.

(2) Help with bath, shampoo, hygiene, and grooming.

(3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

c. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of members unable to eat solid foods.

(2) Assistance with intravenous therapy which is administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood altering or psychotropic drugs or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

d. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall:

- (1) Select the person or agency that will provide the components of the attendant care services.
- (2) Determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.46(2) Home and vehicle modification. Covered home and vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

- (1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.
- (2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.
- (3) Grab bars and handrails.
- (4) Turnaround space adaptations.
- (5) Ramps, lifts, and door, hall and window widening.
- (6) Fire safety alarm equipment specific for disability.
- (7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.
- (8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.
- (9) Keyless entry systems.
- (10) Automatic opening device for home or vehicle door.
- (11) Special door and window locks.
- (12) Specialized doorknobs and handles.
- (13) Plexiglas replacement for glass windows.

- (14) Modification of existing stairs to widen, lower, raise or enclose open stairs.
- (15) Motion detectors.
- (16) Low-pile carpeting or slip-resistant flooring.
- (17) Telecommunications device for the deaf.
- (18) Exterior hard-surface pathways.
- (19) New door opening.
- (20) Pocket doors.
- (21) Installation or relocation of controls, outlets, switches.
- (22) Air conditioning and air filtering if medically necessary.
- (23) Heightening of existing garage door opening to accommodate modified van.
- (24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following department approval of a binding contract between the enrolled home and vehicle modification provider and the member. Whenever possible, three itemized, competitive bids shall be obtained for each project and be reviewed by the case manager or service worker before approval of the contract.

f. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) Personal emergency response or portable locator system.

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) Specialized medical equipment.

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- (1) Provide for the health and safety of the member,
- (2) Are not ordinarily covered by Medicaid,
- (3) Are not funded by educational or vocational rehabilitation programs, and
- (4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

- (1) Electronic aids and organizers.
- (2) Medicine dispensing devices.
- (3) Communication devices.
- (4) Bath aids.
- (5) Noncovered environmental control units.
- (6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to \$6,060 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

- (1) Documented by a health care professional as necessary for the member's health and safety, and
- (2) Identified in the member's service plan.

78.46(5) Transportation. Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

78.46(6) Consumer choices option. The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6) "b"(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment

factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6) "b"(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6) "b"(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6) "b"(2) or the utilization adjustment factor in subparagraph 78.46(6) "b"(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

- (1) The costs of the financial management service.
- (2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual

budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6) "d." Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6) "d." The savings plan shall meet the requirements in paragraph 78.46(6) "f."

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

- (1) The savings plan shall identify:
 1. The specific goods, services, supports or supplies to be purchased through the savings plan.
 2. The amount of the individual budget allocated each month to the savings plan.
 3. The amount of the individual budget allocated each month to meet the member's identified service needs.
 4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.
- (2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct

services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.
(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2).

(3) Schedule the provision of services.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

- (1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.
- (2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.
- (3) Complete the required employment packet with the financial management service.
- (4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.
- (5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.
- (6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.
- (7) Assist the member with negotiating with entities providing services and supports if requested by the member.
- (8) Assist the member with contracts and payment methods for services and supports if requested by the member.
- (9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.
- (10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.
- (11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.
 1. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:
 - (1) Receive Medicaid funds in an electronic transfer.
 - (2) Process and pay invoices for approved goods and services included in the individual budget.
 - (3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.
 - (4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).
 - (5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.
 - (6) Verify for the member an employee's citizenship or alien status.
 - (7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:
 1. Verifying that hourly wages comply with federal and state labor rules.
 2. Collecting and processing timecards.
 3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
 4. Computing and processing other withholdings, as applicable.
 5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
 6. Preparing and issuing employee payroll checks.
 7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
 8. Processing federal advance earned income tax credit for eligible employees.
 9. Refunding over-collected FICA, when appropriate.
 10. Refunding over-collected FUTA, when appropriate.
 - (8) Assist the member in completing required federal, state, and local tax and insurance forms.
 - (9) Establish and manage documents and files for the member and the member's employees.
 - (10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

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

[ARC 9045B, IAB 9/8/10, effective 11/1/10; ARC 9403B, IAB 3/9/11, effective 5/1/11]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) Medicaid recipient eligibility. Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) Provider eligibility. Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) Services. Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be

value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. Initial assessment. The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and

4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. New problem assessments. These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. Problem follow-up assessments. These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. Preventive follow-up assessments. These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) Covered services. Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) Case management services. Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

- (1) Taking the child's history;
- (2) Identifying the needs of the child;
- (3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;
- (4) Completing documentation of the information gathered and the assessment results; and
- (5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

- (1) Include the child's strengths and preferences;
- (2) Consider the child's physical and social environment;
- (3) Specify goals of providing services to the child; and
- (4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.

3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. Documentation of case management. For each child receiving case management, case records must document:

- (1) The name of the child;
- (2) The dates of case management services;
- (3) The agency chosen by the family to provide the case management services;
- (4) The nature, content, and units of case management services received;
- (5) Whether the goals specified in the care plan have been achieved;
- (6) Whether the family has declined services in the care plan;
- (7) Time lines for providing services and reassessment; and
- (8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

- a.* Rescinded IAB 5/10/06, effective 7/1/06.
- b.* The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.
- c.* The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those

vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed \$25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) *General service standards.* All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

78.52(2) Environmental modifications and adaptive devices.

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

- (1) Items ordinarily covered by Medicaid.
- (2) Items funded by educational or vocational rehabilitation programs.
- (3) Items provided by voluntary means.
- (4) Repair and maintenance of items purchased through the waiver.
- (5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

78.52(3) Family and community support services. Family and community support services shall support the consumer and the consumer's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the consumer's and the family's social and emotional strength.

a. Dependent on the needs of the consumer and the consumer's family members individually or collectively, family and community support services may be provided to the consumer, to the consumer's family members, or to the consumer and the family members as a family unit.

b. Family and community support services shall be provided under the recommendation and direction of a mental health professional who is a member of the consumer's interdisciplinary team pursuant to 441—83.127(249A).

c. Family and community support services shall incorporate recommended support interventions and activities, which may include the following:

- (1) Developing and maintaining a crisis support network for the consumer and for the consumer's family.
- (2) Modeling and coaching effective coping strategies for the consumer's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the consumer and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the consumer's positive self-image.
- (8) Developing positive socialization and citizenship skills.

d. Family and community support services may include an amount not to exceed \$1500 per consumer per year for transportation within the community and purchase of therapeutic resources. Therapeutic resources may include books, training materials, and visual or audio media.

(1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.

(2) The annual amount available for transportation and therapeutic resources must be listed in the consumer's service plan.

(3) The consumer's parent or legal guardian shall submit a signed statement that the transportation or therapeutic resource cannot be provided by the consumer or the consumer's family or legal guardian.

(4) The consumer's Medicaid targeted case manager shall maintain a signed statement that potential community resources are unavailable and shall list the community resources contacted to fund the transportation or therapeutic resource.

(5) The transportation or therapeutic resource must not be otherwise eligible for Medicaid reimbursement.

(6) Family and community support services providers shall maintain records to:

1. Ensure that the transportation and therapeutic resources provided do not exceed the maximum amount authorized; and

2. Support the annual reporting requirements in 441—subparagraph 79.1(15)“a”(1).

e. The following components are specifically excluded from family and community support services:

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and consumer care.

f. A unit of family and community support services is one hour.

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the consumer to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is one hour. Any period less than one hour shall be prorated.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The “usual caregiver” means a person or persons who reside with the member and are available on a 24-hour-per-day basis to assume responsibility for the care of the member.

a. Respite care shall not be provided to members during the hours in which the usual caregiver is employed, except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member’s interdisciplinary team. The team shall determine the type of respite care to be provided according to these definitions:

(1) Basic individual respite is provided on a ratio of one staff to one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(2) Specialized respite is provided on a ratio of one or more nursing staff to one member. The member has specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

(3) Group respite is provided on a ratio of one staff to two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.

d. Respite services provided for a period exceeding 24 consecutive hours to three or more members who require nursing care because of a mental or physical condition must be provided by a health care facility licensed under Iowa Code chapter 135C.

e. Respite services provided outside the member’s home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

f. A unit of service is one hour.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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⁰ Two or more ARCs

¹ Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.

³ Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.

⁴ 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.

⁵ 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**.

⁶ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

⁷ July 1, 2009, effective date of amendments to 78.27(2)“d” delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

⁸ May 11, 2011, effective date of 78.34(5)“d,” 78.38(5)“h,” 78.41(2)“g,” 78.43(3)“d,” and 78.52(5)“a” delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 23
EMISSION STANDARDS FOR CONTAMINANTS

[Prior to 7/1/83, DEQ Ch 4]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

567—23.1(455B) Emission standards.

23.1(1) In general. The federal standards of performance for new stationary sources (new source performance standards) shall be applicable as specified in subrule 23.1(2). The federal standards for hazardous air pollutants (national emission standards for hazardous air pollutants) shall be applicable as specified in subrule 23.1(3). The federal standards for hazardous air pollutants for source categories (national emission standards for hazardous air pollutants for source categories) shall be applicable as specified in subrule 23.1(4). The federal emission guidelines (emission guidelines) shall be applicable as specified in subrule 23.1(5). Compliance with emission standards specified elsewhere in this chapter shall be in accordance with 567—Chapter 21.

23.1(2) New source performance standards. The federal standards of performance for new stationary sources, as defined in 40 Code of Federal Regulations Part 60 as amended or corrected through October 8, 2009, are adopted by reference, except § 60.530 through § 60.539b (Part 60, Subpart AAA), and shall apply to the following affected facilities. The corresponding 40 CFR Part 60 subpart designation is in parentheses. Reference test methods (Appendix A), performance specifications (Appendix B), determination of emission rate change (Appendix C), quality assurance procedures (Appendix F) and the general provisions (Subpart A) of 40 CFR Part 60 also apply to the affected facilities.

a. Fossil fuel-fired steam generators. A fossil fuel-fired steam generating unit of more than 250 million Btu heat input for which construction, reconstruction, or modification is commenced after August 17, 1971. Any facility covered under paragraph “z” is not covered under this paragraph. (Subpart D)

b. Incinerators. An incinerator of more than 50 tons per day charging rate. (Subpart E)

c. Portland cement plants. Any of the following in a Portland cement plant: kiln; clinker cooler; raw mill system; finish mill system; raw mill dryer; raw material storage; clinker storage; finished product storage; conveyor transfer points; bagging and bulk loading and unloading systems. (Subpart F)

d. Nitric acid plants. A nitric acid production unit. (Subpart G)

e. Sulfuric acid plants. A sulfuric acid production unit. (Subpart H)

f. Asphalt concrete plants. An asphalt concrete plant. (Subpart I)

g. Petroleum refineries. Any of the following at a petroleum refinery: fluid catalytic cracking unit catalyst regenerator; fluid catalytic cracking unit incinerator-waste heat boilers; fuel gas combustion devices; and claus sulfur recovery plants greater than 20 long tons per day. (Subpart J)

h. Secondary lead smelters. Any of the following in a secondary lead smelter: pot furnaces of more than 250 kilograms (550 pounds) charging capacity; blast (cupola) furnaces; and reverberatory furnaces. (Subpart L)

i. Secondary brass and bronze ingot production plants. Any of the following at a secondary brass and bronze ingot production plant; reverberatory and electric furnaces of 1000/kilograms (2205 pounds) or greater production capacity and blast (cupola) furnaces of 250 kilograms per hour (550 pounds per hour) or greater production capacity. (Subpart M)

j. Iron and steel plants. A basic oxygen process furnace. (Subpart N)

k. Sewage treatment plants. An incinerator which burns the sludge produced by municipal sewage treatment plants. (Subpart O of 40 CFR 60 and Subpart E of 40 CFR 503.)

l. Steel plants. Either of the following at a steel plant: electric arc furnaces and dust-handling equipment, the construction, modification, or reconstruction of which commenced after October 21, 1974, and on or before August 17, 1983. (Subpart AA)

m. Primary copper smelters. Any of the following at a primary copper smelter: dryer, roaster, smelting furnace and copper converter. (Subpart P)

n. Primary zinc smelters. Either of the following at a primary zinc smelter: a roaster or a sintering machine. (Subpart Q)

o. Primary lead smelter. Any of the following at a primary lead smelter: sintering machine, sintering machine discharge end, blast furnace, dross reverberatory furnace, converter and electric smelting furnace. (Subpart R)

p. Primary aluminum reduction plants. Either of the following at a primary aluminum reduction plant: potroom groups and anode bake plants. (Subpart S)

q. Wet process phosphoric acid plants in the phosphate fertilizer industry. A wet process phosphoric acid plant, which includes any combination of the following: reactors, filters, evaporators and hotwells. (Subpart T)

r. Superphosphoric acid plants in the phosphate fertilizer industry. A superphosphoric acid plant which includes any combination of the following: evaporators, hotwells, acid sumps, and cooling tanks. (Subpart U)

s. Diammonium phosphate plants in the phosphate fertilizer industry. A granular diammonium phosphate plant which includes any combination of the following: reactors, granulators, dryers, coolers, screens and mills. (Subpart V)

t. Triple super phosphate plants in the phosphate fertilizer industry. A triple super phosphate plant which includes any combination of the following: mixers, curing belts (dens), reactors, granulators, dryers, cookers, screens, mills and facilities which store run-of-pile triple superphosphate. (Subpart W)

u. Granular triple superphosphate storage facilities in the phosphate fertilizer industry. A granular triple superphosphate storage facility which includes any combination of the following: storage or curing piles, conveyors, elevators, screens and mills. (Subpart X)

v. Coal preparation plants. Any of the following at a coal preparation plant which processes more than 200 tons per day: thermal dryers; pneumatic coal cleaning equipment (air tables); coal processing and conveying equipment (including breakers and crushers); coal storage systems; and coal transfer and loading systems. (Subpart Y)

w. Ferroalloy production. Any of the following: electric submerged arc furnaces which produce silicon metal, ferrosilicon, calcium silicon, silicomanganese zirconium, ferrochrome silicon, silvery iron, high-carbon ferrochrome, charge chrome, standard ferromanganese, silicomanganese, ferromanganese silicon, or calcium carbide; and dust-handling equipment. (Subpart Z)

x. Kraft pulp mills. Any of the following in a kraft pulp mill: digester system; brown stock washer system; multiple effect evaporator system; black liquor oxidation system; recovery furnace; smelt dissolving tank; lime kiln; and condensate stripper system. In pulp mills where kraft pulping is combined with neutral sulfite semichemical pulping, the provisions of the standard of performance are applicable when any portion of the material charged to an affected facility is produced by the kraft pulping operation. (Subpart BB)

y. Lime manufacturing plants. A rotary lime kiln or a lime hydrator used in the manufacture of lime at other than a kraft pulp mill. (Subpart HH)

z. Electric utility steam generating units. An electric utility steam generating unit that is capable of combusting more than 250 million Btus per hour (73 megawatts) heat input of fossil fuel for which construction or modification or reconstruction is commenced after September 18, 1978, or an electric utility combined cycle gas turbine that is capable of combusting more than 250 million Btus per hour (73 megawatts) heat input. "Electric utility steam generating unit" means any steam electric generating unit that is constructed for the purpose of supplying more than one-third of its potential electric output capacity and more than 25 MW net-electrical output to any utility power distribution system for sale. Also, any steam supplied to a steam distribution system for the purpose of providing steam to a steam electric generator that would produce electrical energy for sale is considered in determining the electrical energy output capacity of the affected facility. (Subpart Da)

aa. Stationary gas turbines. Any simple cycle gas turbine, regenerative cycle gas turbine or any gas turbine portion of a combined cycle steam/electric generating system that is not self-propelled. It may, however, be mounted on a vehicle for portability. (Subpart GG)

bb. Petroleum storage vessels. Unless exempted, any storage vessel for petroleum liquids for which the construction, reconstruction, or modification commenced after June 11, 1973, and prior to May 19, 1978, having a storage capacity greater than 151,412 liters (40,000 gallons). (Subpart K)

- cc. Petroleum storage vessels.* Unless exempted, any storage vessel for petroleum liquids for which the construction, reconstruction, or modification commenced after May 18, 1978, and prior to July 23, 1984, having a storage capacity greater than 151,416 liters (40,000 gallons). (Subpart Ka)
- dd. Glass manufacturing plants.* Any glass melting furnace. (Subpart CC)
- ee. Automobile and light-duty truck surface coating operations at assembly plants.* Any of the following in an automobile or light-duty truck assembly plant: prime coat operations, guide coat operations, and topcoat operations. (Subpart MM)
- ff. Ammonium sulfate manufacture.* Any of the following in the ammonium sulfate industry: ammonium sulfate dryers in the caprolactam by-product, synthetic, and coke oven by-product sectors of the industry. (Subpart PP)
- gg. Surface coating of metal furniture.* Any metal furniture surface coating operation in which organic coatings are applied. (Subpart EE)
- hh. Lead-acid battery manufacturing plants.* Any lead-acid battery manufacturing plant which uses any of the following: grid casting, paste mixing, three-process operation, lead oxide manufacturing, lead reclamation, other lead-emitting operations. (Subpart KK)
- ii. Phosphate rock plants.* Any phosphate rock plant which has a maximum plant production capacity greater than four tons per hour including the following: dryers, calciners, grinders, and ground rock handling and storage facilities, except those facilities producing or preparing phosphate rock solely for consumption in elemental phosphorus production. (Subpart NN)
- jj. Graphic arts industry.* Publication rotogravure printing. Any publication rotogravure printing press except proof presses. (Subpart QQ)
- kk. Industrial surface coating — large appliances.* Any surface coating operation in a large appliance surface coating line. (Subpart SS)
- ll. Metal coil surface coating.* Any of the following at a metal coil surface coating operation: prime coat operation, finish coat operation, and each prime and finish coat operation combined when the finish coat is applied wet-on-wet over the prime coat and both coatings are cured simultaneously. (Subpart TT)
- mm. Asphalt processing and asphalt roofing manufacturing.* Any saturator, mineral handling and storage facility at asphalt roofing plants; and any asphalt storage tank and any blowing still at asphalt processing plants, petroleum refineries, and asphalt roofing plants. (Subpart UU)
- nn. Equipment leaks of volatile organic compounds (VOC) in the synthetic organic chemicals manufacturing industry.* Standards for affected facilities in the synthetic organic chemicals manufacturing industry (SOCMI) that commenced construction, reconstruction, or modification after January 5, 1981, and on or before November 7, 2006, are set forth in Subpart VV. Standards for affected SOCMI facilities that commenced construction, reconstruction or modification after November 7, 2006, are set forth in Subpart VVa. The standards apply to pumps, compressors, pressure relief devices, sampling systems, open-ended valves or lines (OEL), valves, and flanges or other connectors which handle VOC. (Subpart VV and Subpart VVa)
- oo. Beverage can surface coating.* Any beverage can surface coating lines for two-piece steel or aluminum containers in which soft drinks or beer are sold. (Subpart WW)
- pp. Bulk gasoline terminals.* The total of all loading racks at bulk gasoline terminals which deliver liquid product into gasoline tank trucks. (Subpart XX)
- qq. Pressure sensitive tape and label surface coating operations.* Any coating line used in the tape manufacture of pressure sensitive tape and label materials. (Subpart RR)
- rr. Metallic mineral processing plants.* Any ore processing and handling equipment. (Subpart LL)
- ss. Synthetic fiber production facilities.* Any solvent-spun synthetic fiber process that produces more than 500 megagrams of fiber per year. (Subpart HHH)
- tt. Equipment leaks of VOC in petroleum refineries.* A compressor and all equipment (defined in 40 CFR, Part 60.591) within a process unit for which the construction, reconstruction, or modification commenced after January 4, 1983. (Subpart GGG)
- uu. Flexible vinyl and urethane coating and printing.* Each rotogravure printing line used to print or coat flexible vinyl or urethane products. (Subpart FFF)

vv. *Petroleum dry cleaners.* Petroleum dry-cleaning plant with a total manufacturer's rated dryer capacity equal to or greater than 38 kilograms (84 pounds): petroleum solvent dry-cleaning dryers, washers, filters, stills, and settling tanks. (Subpart JJJ)

ww. *Electric arc furnaces and argon-oxygen decarburization vessels constructed after August 17, 1983.* Steel plants that produce carbon, alloy, or specialty steels: electric arc furnaces, argon-oxygen decarburization vessels, and dust-handling systems. (Subpart AAa)

xx. *Wool fiberglass insulation manufacturing plants.* Rotary spin wool fiberglass manufacturing line. (Subpart PPP)

yy. *Iron and steel plants.* Secondary emissions from basic oxygen process steelmaking facilities for which construction, reconstruction, or modification commenced after January 20, 1983. (Subpart Na)

zz. *Equipment leaks of VOC from on-shore natural gas processing plants.* A compressor and all equipment defined in 40 CFR, Part 60.631, unless exempted, for which construction, reconstruction, or modification commenced after January 20, 1984. (Subpart KKK)

aaa. *On-shore natural gas processing: SO₂ emissions.* Unless exempted, each sweetening unit and each sweetening unit followed by a sulfur recovery unit for which construction, reconstruction, or modification commenced after January 20, 1984. (Subpart LLL)

bbb. *Nonmetallic mineral processing plants.* Unless exempted, each crusher, grinding mill, screening operation, bucket elevator, belt conveyor, bagging operation, storage bin, enclosed truck or rail car loading station in fixed or portable nonmetallic mineral processing plants for which construction, reconstruction, or modification commenced after August 31, 1983. (Subpart OOO)

ccc. *Industrial-commercial-institutional steam generating units.* Unless exempted, each steam generating unit for which construction, reconstruction, or modification commenced after June 19, 1984, and which has a heat input capacity of more than 100 million Btu/hour. (Subpart Db)

ddd. *Volatile organic liquid storage vessels.* Unless exempted, volatile organic liquid storage vessels for which construction, reconstruction, or modification commenced after July 23, 1984. (Subpart Kb)

eee. *Rubber tire manufacturing plants.* Unless exempted, each undertread cementing operation, each sidewall cementing operation, each tread end cementing operation, each bead cementing operation, each green tire spraying operation, each Michelin-A operation, each Michelin-B operation, and each Michelin-C automatic operation that commences construction or modification after January 20, 1983. (Subpart BBB)

fff. *Industrial surface coating: surface coating of plastic parts for business machines.* Each spray booth in which plastic parts for use in the manufacture of business machines receive prime coats, color coats, texture coats, or touch-up coats for which construction, modification, or reconstruction begins after January 8, 1986. (Subpart TTT)

ggg. *VOC emissions from petroleum refinery wastewater systems.* Each individual drain system, each oil-water separator, and each aggregate facility for which construction, modification or reconstruction is commenced after May 4, 1987. (Subpart QQQ)

hhh. *Magnetic tape coating facilities.* Unless exempted, each coating operation and each piece of coating mix preparation equipment for which construction, modification, or reconstruction is commenced after January 22, 1986. (Subpart SSS)

iii. *Polymeric coating of supporting substrates.* Unless exempted, each coating operation and any on-site coating mix preparation equipment used to prepare coatings for the polymeric coating of supporting substrates for which construction, modification, or reconstruction begins after April 30, 1987. (Subpart VVV)

jjj. *VOC emissions from synthetic organic chemical manufacturing industry air oxidation unit processes.* Unless exempted, any air oxidation reactor, air oxidation reactor and recovery system or combination of two or more reactors and the common recovery system used in the production of any of the chemicals listed in 40 CFR §60.617 for which construction, modification or reconstruction commenced after October 21, 1983. (Subpart III)

kkk. *VOC emissions from synthetic organic chemical manufacturing industry distillation operations.* Unless exempted, any distillation unit, distillation unit and recovery system or combination

of two or more distillation units and the common recovery system used in the production of any of the chemicals listed in 40 CFR §60.667 for which construction, modification or reconstruction commenced after December 30, 1983. (Subpart NNN)

lll. Small industrial-commercial-institutional steam generating units. Each steam generating unit for which construction, modification, or reconstruction is commenced after June 9, 1989, and that has a maximum design heat input capacity of 100 million Btu per hour or less, but greater than or equal to 10 million Btu per hour. (Subpart Dc)

mmm. VOC emissions from the polymer manufacturing industry. Each of the following process sections in the manufacture of polypropylene and polyethylene—raw materials preparation, polymerization reaction, material recovery, product finishing, and product storage; each material recovery section of polystyrene manufacturing using a continuous process; each polymerization reaction section of poly(ethylene terephthalate) manufacturing using a continuous process; each material recovery section of poly(ethylene terephthalate) manufacturing using a continuous process that uses dimethyl terephthalate; each raw material section of poly(ethylene terephthalate) manufacturing using a continuous process that uses terephthalic acid; and each group of fugitive emissions equipment within any process unit in the manufacturing of polypropylene, polyethylene, or polystyrene (including expandable polystyrene). The applicability date for construction, modification or reconstruction for polystyrene and poly(ethylene terephthalate) affected facilities and some polypropylene and polyethylene affected facilities is September 30, 1987. For the other polypropylene and polyethylene affected facilities the applicability date for these regulations is January 10, 1989. (Subpart DDD)

nnn. Municipal waste combustors. Unless exempted, a municipal waste combustor with a capacity greater than 225 megagrams per day of municipal solid waste for which construction is commenced after December 20, 1989, and on or before September 20, 1994, and modification or reconstruction is commenced after December 20, 1989, and on or before June 19, 1996. (Subpart Ea)

ooo. Grain elevators. A grain terminal elevator or any grain storage elevator except as provided under 40 CFR 60.304(b), August 31, 1993. A grain terminal elevator means any grain elevator which has a permanent storage capacity of more than 2.5 million U.S. bushels except those located at animal food manufacturers, pet food manufacturers, cereal manufacturers, breweries, and livestock feedlots. A grain storage elevator means any grain elevator located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant which has a permanent grain storage capacity of 1 million bushels. Any construction, modification, or reconstruction after August 3, 1978, is subject to this paragraph. (Subpart DD)

ppp. Mineral processing plants. Each calciner and dryer at a mineral processing plant unless excluded for which construction, modification, or reconstruction is commenced after April 23, 1986. (Subpart UUU)

qqq. VOC emissions from synthetic organic chemical manufacturing industry reactor processes. Unless exempted, each affected facility that is part of a process unit that produces any of the chemicals listed in 40 CFR §60.707 as a product, coproduct, by-product, or intermediate for which construction, modification, or reconstruction commenced after June 29, 1990. Affected facility is each reactor process not discharging its vent stream into a recovery system, each combination of a reactor process and the recovery system into which its vent stream is discharged, or each combination of two or more reactor processes and the common recovery system into which their vent streams are discharged. (Subpart RRR)

rrr. Municipal solid waste landfills, as defined by 40 CFR 60.751. Each municipal solid waste landfill that commenced construction, reconstruction or modification or began accepting waste on or after May 30, 1991, must comply. (Subpart WWW)

sss. Municipal waste combustors. Unless exempted, a municipal waste combustor with a combustion capacity greater than 250 tons per day of municipal solid waste for which construction, modification or reconstruction is commenced after September 20, 1994, or for which modification or reconstruction is commenced after June 19, 1996. (Subpart Eb)

ttt. Hospital/medical/infectious waste incinerators. Unless exempted, a hospital/medical/infectious waste incinerator for which construction is commenced after June 20, 1996, or for which modification is commenced after March 16, 1998. (Subpart Ec)*

*As of November 24, 2010, the adoption by reference of Part 60 Subpart Ec is rescinded.

uuu. New small municipal waste combustion units. Unless exempted, this standard applies to a small municipal waste combustion unit that commenced construction after August 30, 1999, or small municipal waste combustion units that commenced reconstruction or modification after June 6, 2001. (Part 60, Subpart AAAA)

vvv. Commercial and industrial solid waste incineration. Unless exempted, this standard applies to units for which construction is commenced after November 30, 1999, or for which modification or reconstruction is commenced on or after June 1, 2001. (Part 60, Subpart CCCC)

www. Other solid waste incineration (OSWI) units. Unless exempted, this standard applies to other solid waste incineration (OSWI) units for which construction is commenced after December 9, 2004, or for which modification or reconstruction is commenced on or after June 16, 2006. (Part 60, Subpart EEEE)

xxx. Reserved.

yyy. Stationary compression ignition internal combustion engines. Unless otherwise exempted, these standards apply to each stationary compression ignition internal combustion engine whose construction, modification or reconstruction commenced after July 11, 2005. (Part 60, Subpart IIII)

zzz. Stationary spark ignition internal combustion engines. These standards apply to each stationary spark ignition internal combustion engine whose construction, modification or reconstruction commenced after June 12, 2006. (Part 60, Subpart JJJJ)

aaaa. Stationary combustion turbines. Unless otherwise exempted, these standards apply to stationary combustion turbines with a heat input at peak load equal to or greater than 10 MMBtu per hour, based on the higher heating value of the fuel, that commence construction, modification, or reconstruction after February 18, 2005. (Part 60, Subpart KKKK)

23.1(3) Emission standards for hazardous air pollutants. The federal standards for emissions of hazardous air pollutants, 40 Code of Federal Regulations Part 61 as amended or corrected through May 16, 2007, and 40 CFR Part 503 as adopted on August 4, 1999, are adopted by reference, except 40 CFR §61.20 to §61.26, §61.90 to §61.97, §61.100 to §61.108, §61.120 to §61.127, §61.190 to §61.193, §61.200 to §61.205, §61.220 to §61.225, and §61.250 to §61.256, and shall apply to the following affected pollutants and facilities and activities listed below. The corresponding 40 CFR Part 61 subpart designation is in parentheses. Reference test methods (Appendix B), compliance status information requirements (Appendix A), quality assurance procedures (Appendix C) and the general provisions (Subpart A) of Part 61 also apply to the affected activities or facilities.

a. Asbestos. Any of the following involves asbestos emissions: asbestos mills, surfacing of roadways, manufacturing operations, fabricating, insulating, waste disposal, spraying applications and demolition and renovation operations. (Subpart M)

b. Beryllium. Any of the following stationary sources: beryllium extraction plants, ceramic plants, foundries, incinerators, and propellant plants which process beryllium ore, beryllium oxide, beryllium alloys, or beryllium-containing waste; and machine shops which process beryllium, beryllium oxides, or any alloy when such alloy contains more than 5 percent beryllium by weight. (Subpart C)

c. Beryllium rocket motor firing. Rocket motor test sites. (Subpart D)

d. Mercury. Any of the following involving mercury emissions: mercury ore processing facilities, mercury cell chlor-alkali plants, sludge incineration plants, sludge drying plants, and a combination of sludge incineration plants and sludge drying plants. (Subpart E)

e. Vinyl chloride. Ethylene dichloride purification and the oxychlorination reactor in ethylene dichloride plants. Vinyl chloride formation and purification in vinyl chloride plants. Any of the following involving polyvinyl chloride plants: reactor; stripper; mixing, weighing, and holding containers; monomer recovery system; sources following the stripper(s). Any of the following involving ethylene dichloride, vinyl chloride, and polyvinyl chloride plants: relief valve discharge; fugitive emission sources. (Subpart F)

f. Equipment leaks of benzene (fugitive emission sources). Any pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, flanges and other connectors, product accumulator vessels, and control devices or systems which handle benzene. (Subpart J)

g. Equipment leaks of volatile hazardous air pollutants (fugitive emission sources). Any pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, flanges and other connectors, product accumulator vessels, and control devices or systems which handle volatile hazardous air pollutants. (Subpart V)

h. Inorganic arsenic emissions from arsenic trioxide and metallic arsenic production facilities. Each metallic arsenic production plant and each arsenic trioxide plant that processes low-grade arsenic bearing materials by a roasting condensation process. (Subpart P)

i. Inorganic arsenic emissions from glass manufacturing plants. Each glass melting furnace (except pot furnaces) that uses commercial arsenic as a raw material. (Subpart N)

j. Inorganic arsenic emissions from primary copper smelters. Each copper converter at any new or existing primary copper smelter except as noted in 40 CFR §61.172(a). (Subpart O)

k. Benzene emissions from coke by-product recovery plants. Each of the following sources at furnace and foundry coke by-product recovery plants: tar decanters, tar storage tanks, tar-intercepting sumps, flushing-liquor circulation tanks, light-oil sumps, light-oil condensers, light-oil decanters, wash-oil decanters, wash-oil circulation tanks, naphthalene processing, final coolers, final-cooler cooling towers, and the following equipment that is intended to operate in benzene service: pumps, valves, exhausters, pressure relief devices, sampling connection systems, open-ended valves or lines, flanges or other connectors, and control devices or systems required by 40 CFR §61.135.

The provisions of this subpart also apply to benzene storage tanks, BTX storage tanks, light-oil storage tanks, and excess ammonia-liquor storage tanks at furnace coke by-product recovery plants. (Subpart L)

l. Benzene emissions from benzene storage vessels. Unless exempted, each storage vessel that is storing benzene having a specific gravity within the range of specific gravities specified in ASTM D 836-84 for Industrial Grade Benzene, ASTM D 835-85 for Refined Benzene-485, ASTM D 2359-85a for Refined Benzene-535, and ASTM D 4734-87 for Refined Benzene-545. These specifications are incorporated by reference as specified in 40 CFR §61.18. (Subpart Y)

m. Benzene emissions from benzene transfer operations. Unless exempted, the total of all loading racks at which benzene is loaded into tank trucks, rail cars, or marine vessels at each benzene production facility and each bulk terminal. (Subpart BB)

n. Benzene waste operations. Unless exempted, the provisions of this subrule apply to owners and operators of chemical manufacturing plants, coke by-product recovery plants, petroleum refineries, and facilities at which waste management units are used to treat, store, or dispose of waste generated by any of these listed facilities. (Subpart FF)

23.1(4) Emission standards for hazardous air pollutants for source categories. The federal standards for emissions of hazardous air pollutants for source categories, 40 Code of Federal Regulations Part 63 as amended or corrected through December 22, 2008, are adopted by reference, except those provisions which cannot be delegated to the states. The corresponding 40 CFR Part 63 subpart designation is in parentheses. An earlier date for adoption by reference may be included with the subpart designation in parentheses. 40 CFR Part 63, Subpart B, incorporates the requirements of Clean Air Act Sections 112(g) and 112(j) and does not adopt standards for a specific affected facility. Test methods (Appendix A), sources defined for early reduction provisions (Appendix B), and determination of the fraction biodegraded (F_{bio}) in the biological treatment unit (Appendix C) of Part 63 also apply to the affected activities or facilities. For the purposes of this subrule, “hazardous air pollutant” has the same meaning found in 567—22.100(455B). For the purposes of this subrule, a “major source” means any stationary source or group of stationary sources located within a contiguous area and under common control that emits or has the potential to emit, considering controls, in the aggregate, 10 tons per year or more of any hazardous air pollutant or 25 tons per year or more of any combination of hazardous air pollutants, unless a lesser quantity is established, or in the case of radionuclides, where

different criteria are employed. For the purposes of this subrule, an “area source” means any stationary source of hazardous air pollutants that is not a “major source” as defined in this subrule. Paragraph 23.1(4)“a,” general provisions (Subpart A) of Part 63, shall apply to owners or operators who are subject to subsequent subparts of 40 CFR Part 63 (except when otherwise specified in a particular subpart or in a relevant standard) as adopted by reference below.

a. General provisions. General provisions apply to owners or operators of affected activities or facilities except when otherwise specified in a particular subpart or in a relevant standard. (Subpart A)

b. Requirements for control technology determinations for major sources in accordance with Clean Air Act Sections 112(g) and 112(j). (40 CFR Part 63, Subpart B)

(1) Section 112(g) requirements. For the purposes of this subparagraph, the definitions shall be the same as the definitions found in 40 CFR 63.2 and 40 CFR 63.41 as amended through December 27, 1996. The owner or operator of a new or reconstructed major source of hazardous air pollutants must apply maximum achievable control technology (MACT) for new sources to the new or reconstructed major source. If the major source in question has been specifically regulated or exempted from regulation under a standard issued pursuant to Section 112(d), Section 112(h), or Section 112(j) of the Clean Air Act and incorporated in another subpart of 40 CFR Part 63, excluded in 40 CFR 63.40(e) and (f), or the owner or operator of such major source has received all necessary air quality permits for such construction or reconstruction project before June 29, 1998, then the major source in question is not subject to the requirements of this subparagraph. The owner or operator of an affected source shall apply for a construction permit as required in 567—paragraph 22.1(1)“b.” The construction permit application shall contain an application for a case-by-case MACT determination for the major source.

(2) Section 112(j) requirements. The owner or operator of a new or existing major source of hazardous air pollutants which includes one or more stationary sources included in a source category or subcategory for which the U.S. Environmental Protection Agency has failed to promulgate an emission standard within 18 months of the deadline established under CAA 112(d) must submit a MACT application (Parts 1 and 2) in accordance with the provisions of 40 CFR 63.52, as amended through April 5, 2002, by the CAA Section 112(j) deadline. In addition, the owner or operator of a new emission unit may submit an application for a Notice of MACT Approval before construction, as defined in 40 CFR 63.41, in accordance with the provisions of 567—paragraph 22.1(3)“a.”

c. Reserved.

d. Compliance extensions for early reductions of hazardous air pollutants. Compliance extensions for early reductions of hazardous air pollutants are available to certain owners or operators of an existing source who wish to obtain a compliance extension from a standard issued under Section 112(d) of the Act. (Subpart D)

e. Reserved.

f. Emission standards for organic hazardous air pollutants from the synthetic chemical manufacturing industry. These standards apply to chemical manufacturing process units that are part of a major source. These standards include applicability provisions, definitions and other general provisions that are applicable to Subparts F, G, and H of 40 CFR 63. (Subpart F)

g. Emission standards for organic hazardous air pollutants from the synthetic organic chemical manufacturing industry for process vents, storage vessels, transfer operations, and wastewater. These standards apply to all process vents, storage vessels, transfer racks, and wastewater streams within a source subject to Subpart F of 40 CFR 63. (Subpart G)

h. Emission standards for organic hazardous air pollutants for equipment leaks. These standards apply to emissions of designated organic hazardous air pollutants from specified processes that are located at a plant site that is a major source. Affected equipment includes: pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, surge control vessels, bottoms receivers, instrumentation systems and control devices or systems required by this subpart that are intended to operate in organic hazardous air pollutant service 300 hours or more during the calendar year within a source subject to the provisions of a specific subpart in 40 CFR Part 63. In organic hazardous air pollutant or in organic HAP service means that a piece of equipment either contains or contacts a fluid (liquid or gas) that is at least 5 percent by weight

of total organic HAPs as determined according to the provisions of 40 CFR Part 63.161. The provisions of 40 CFR Part 63.161 also specify how to determine that a piece of equipment is not in organic HAP service. (Subpart H)

i. Emission standards for organic hazardous air pollutants for certain processes subject to negotiated regulation for equipment leaks. These standards apply to emissions of designated organic hazardous air pollutants from specified processes (defined in 40 CFR 63.190) that are located at a plant site that is a major source. Subject equipment includes pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, and instrumentation systems at certain source categories. These standards establish the applicability of Subpart H for sources that are not classified as synthetic organic chemical manufacturing industries. (Subpart I)

j. Emission standards for hazardous air pollutants for polyvinyl chloride and copolymers production. This standard applies to a polyvinyl chloride (PVC) or copolymer production facility that is located at, or is part of, a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart J)

k. Reserved.

l. Emission standards for coke oven batteries. These standards apply to existing coke oven batteries, including by-product and nonrecovery coke oven batteries and to new coke oven batteries, or as defined in the subpart. (Subpart L)

m. Perchloroethylene air emission standards for dry cleaning facilities (40 CFR Part 63, Subpart M). These standards apply to the owner or operator of each dry cleaning facility that uses perchloroethylene (also known as perc). The specific standards applicable to dry cleaning facilities, including the compliance deadlines, are set out in the federal regulations contained in Subpart M. In general, dry cleaning facilities must meet the following requirements, which are set out in greater detail in Subpart M:

(1) New and existing major source dry cleaning facilities are required to control emissions to the level of the maximum achievable control technology (MACT).

(2) New and existing area source dry cleaning facilities are required to control emissions to the level achieved by generally available control technologies (GACT) or management practices.

(3) New area sources that are located in residential buildings and that commence operation after July 13, 2006, are prohibited from using perc.

(4) New area sources located in residential buildings that commenced operation between December 21, 2005, and July 13, 2006, must eliminate all use of perc by July 27, 2009.

(5) Existing area sources located in residential buildings must eliminate all use of perc by December 21, 2020.

(6) New area sources that are not located in residential buildings are prohibited from operating transfer machines.

(7) Existing area sources that are not located in residential buildings are prohibited from operating transfer machines after July 27, 2008.

(8) All sources must comply with the requirements in Subpart M for emissions control, equipment specifications, leak detection and repair, work practice standards, record keeping and reporting.

n. Emission standards for chromium emissions from hard and decorative chromium electroplating and chromium anodizing tanks. These standards limit the discharge of chromium compound air emissions from existing and new hard chromium electroplating, decorative chromium electroplating, and chromium anodizing tanks at major and area sources. (Subpart N)

o. Emission standards for hazardous air pollutants for ethylene oxide commercial sterilization and fumigation operations. New and existing major source ethylene oxide commercial sterilization and fumigation operations are required to control emissions to the level of the maximum achievable control technology (MACT). New and existing area source ethylene oxide commercial sterilization and fumigation operations are required to control emissions to the level achieved by generally available control technologies (GACT). Certain sources are exempt as described in 40 CFR 63.360. (Subpart O)

p. Emission standards for primary aluminum reduction plants. These standards apply to each new or existing potline, paste production plant, or anode bake furnace associated with a primary aluminum

reduction plant, and for each new pitch storage tank associated with a primary aluminum production plant, except existing furnaces not located on the same site as the primary aluminum reduction plant. (Subpart LL)

q. Emission standards for hazardous air pollutants for industrial process cooling towers. These standards apply to all new and existing industrial process cooling towers that are operated with chromium-based water treatment chemicals on or after September 8, 1994, and are either major sources or are integral parts of facilities that are major sources. (Subpart Q)

r. Emission standards for hazardous air pollutants for sources categories: gasoline distribution: (Stage 1). These standards apply to all existing and new bulk gasoline terminals and pipeline breakout stations that are major sources of hazardous air pollutants or are located at plant sites that are major sources. Bulk gasoline terminals and pipeline breakout stations located within a contiguous area or under common control with a refinery complying with 40 CFR Subpart CC are not subject to 40 CFR Subpart R standards. (Subpart R)

s. Emission standards for hazardous air pollutants for pulp and paper (noncombustion). These standards apply to pulping and bleaching process sources at kraft, soda, sulfite, and stand-alone semichemical pulp mills. Affected sources include pulp mills and integrated mills (mills that manufacture pulp and paper/paperboard) that chemically pulp wood fiber (using kraft, sulfite, soda, or semichemical methods); pulp secondary fiber; pulp nonwood fiber; and mechanically pulp wood fiber. (Subpart S)

t. Emission standards for hazardous air pollutants: halogenated solvent cleaning. These standards require batch vapor solvent cleaning machines and in-line solvent cleaning machines to meet emission standards reflecting the application of maximum achievable control technology (MACT) for major and area sources; area source batch cold cleaning machines are required to achieve generally available control technology (GACT). The subpart regulates the emissions of the following halogenated hazardous air pollutant solvents: methylene chloride, perchloroethylene, trichloroethylene, 1,1,1-trichloroethane, carbon tetrachloride, and chloroform. (Subpart T)

u. Emission standards for hazardous air pollutants: Group I polymers and resins. Applicable to existing and new major sources that emit organic HAP during the manufacture of one or more elastomers including but not limited to producers of butyl rubber, halobutyl rubber, epichlorohydrin elastomers, ethylene propylene rubber, Hypalon™, neoprene, nitrile butadiene rubber, nitrile butadiene latex, polybutadiene rubber/styrene butadiene rubber by solution, polysulfide rubber, styrene butadiene rubber by emulsion, and styrene butadiene latex. MACT is required for major sources. (Subpart U)

v. Reserved.

w. Emission standards for hazardous air pollutants for epoxy resins production and nonnylon polyamides production. These standards apply to all existing, new and reconstructed manufacturers of basic liquid epoxy resins and manufacturers of wet strength resins that are located at a plant site that is a major source. (Subpart W)

x. National emission standards for hazardous air pollutants from secondary lead smelting. These standards apply to all existing and new secondary lead smelters sources which use blast, reverberatory, rotary, or electric smelting furnaces for lead recovery of scrap lead that are located at major or area sources. The provisions apply to smelting furnaces, refining kettles, agglomerating furnaces, dryers, process fugitive sources, and fugitive dust. Excluded from the rule are primary lead smelters, lead refiners, and lead remelters. Hazardous air pollutants regulated under this standard include but are not limited to lead compounds, arsenic compounds, and 1,3-butadiene. (Subpart X)

y. Emission standards for marine tank vessel loading operations. This standard requires existing and new major sources to control emissions using maximum achievable control technology (MACT) to control hazardous air pollutants (HAP). (Subpart Y)

z. Reserved.

aa. Emission standards for hazardous air pollutants for phosphoric acid manufacturing. These standards apply to all new and existing major sources of phosphoric acid manufacturing. Affected processes include, but are not limited to, wet process phosphoric acid process lines, superphosphoric

acid process lines, phosphate rock dryers, phosphate rock calciners, and purified phosphoric acid process lines. (Subpart AA)

ab. Emission standards for hazardous air pollutants for phosphate fertilizers production. These standards apply to all new and existing major sources of phosphate fertilizer production plants. Affected processes include, but are not limited to, diammonium and monoammonium phosphate process lines, granular triple superphosphate process lines, and granular triple superphosphate storage buildings. (Subpart BB)

ac. National emission standards for hazardous air pollutants: petroleum refineries. These standards apply to petroleum refining process units and colocated emission points at new and existing major sources. Affected sources include process vents, equipment leaks, storage vessels, transfer operations, and wastewater streams. The standards also apply to marine tank vessel and gasoline loading racks. Excluded from the standard are catalyst regeneration from catalytic cracking units and catalytic reforming units, and vents from sulfur recovery units. Compliance with the standard includes emission control and prevention. (Subpart CC)

ad. Emission standards for hazardous air pollutants for off-site waste and recovery operations. This rule applies to major sources of HAP emissions which receive certain wastes, used oil, and used solvents from off-site locations for storage, treatment, recovery, or disposal at the facility. Maximum achievable control technology (MACT) is required to reduce HAP emissions from tanks, surface impoundments, containers, oil-water separators, individual drain systems and other material conveyance systems, process vents, and equipment leaks. Regulated entities include but are not limited to businesses that operate any of the following: hazardous waste treatment, storage, and disposal facilities; Resource Conservation and Recovery Act (RCRA) exempt hazardous wastewater treatment facilities other than publicly owned treatment works; used solvent recovery plants; RCRA exempt hazardous waste recycling operations; used oil re-refineries. The regulations also apply to federal agency facilities that operate any of the waste management or recovery operations. (Subpart DD)

ae. Emission standards for magnetic tape manufacturing operations. These standards apply to major sources performing magnetic tape manufacturing operations. (Subpart EE)

af. Reserved.

ag. National emission standards for hazardous air pollutants for source categories: aerospace manufacturing and rework facilities. These standards apply to major sources involved in the manufacture, repair, or rework of aerospace components and assemblies, including but not limited to airplanes, helicopters, missiles, and rockets for civil, commercial, or military purposes. Hazardous air pollutants regulated under this standard include chromium, cadmium, methylene chloride, toluene, xylene, methyl ethyl ketone, ethylene glycol, and glycol ethers. (Subpart GG)

ah. Emission standards for hazardous air pollutants for oil and natural gas production. These standards apply to all new and existing major sources of oil and natural gas production. Affected sources include, but are not limited to, processing of liquid or gaseous hydrocarbons, such as ethane, propane, butane, pentane, natural gas, and condensate extracted from field natural gas. (Subpart HH)

ai. Emission standards for hazardous air pollutants for shipbuilding and ship repair (surface coating) operations. Requires existing and new major sources to control hazardous air pollutant (HAP) emissions using the maximum achievable control technology (MACT). (Subpart II)

aj. Emission standards for hazardous air pollutants for hazardous air pollutant (HAP) emissions from wood furniture manufacturing operations. These standards apply to each facility that is engaged, either in part or in whole, in the manufacture of wood furniture or wood furniture components and that is located at a plant site that is a major source. (Subpart JJ)

ak. Emission standards for hazardous air pollutants for the printing and publishing industry. Existing and new major sources are required to control hazardous air pollutants (HAP) using the maximum achievable control technology (MACT). Affected units are publication rotogravure, product and packaging rotogravure, and wide-web flexographic printing. (Subpart KK)

al. Emission standards for hazardous air pollutants for primary aluminum reduction plants. These standards apply to each new or existing potline, paste production plant, and anode bake furnace

associated with a primary aluminum reduction plant, and for each new pitch storage tank associated with a primary aluminum production plant. (Part 63, Subpart LL)

am. Emission standards for hazardous air pollutants for chemical recovery combustion sources at kraft, soda, sulfite, and stand-alone semichemical pulp mills. (Part 63, Subpart MM)

an. Reserved.

ao. Emission standards for tanks – level 1. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart OO)

ap. Emission standards for containers. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart PP)

aq. Emission standards for surface impoundments. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart QQ)

ar. Emission standards for individual drain systems. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart RR)

as. Emission standards for closed vent systems, control devices, recovery devices and routing to a fuel gas system or a process. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart SS)

at. Emission standards for equipment leaks—control level 1. These provisions apply to the control of air emissions from equipment leaks for which another paragraph under this rule references the use of this paragraph for such emission control. These air emission standards for equipment leaks are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart TT)

au. Emission standards for equipment leaks—control level 2 standards. These provisions apply to the control of air emissions from equipment leaks for which another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards for equipment leaks are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart UU)

av. Emission standards for oil-water separators and organic-water separators. These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph

23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart VV)

aw. Emission standards for storage vessels (tanks)—control level 2. These provisions apply to the control of air emissions from storage vessels for which another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards for storage vessels are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart WW)

ax. Emission standards for ethylene manufacturing process units: heat exchange systems and waste operations. This standard applies to hazardous air pollutants (HAPs) from heat exchange systems and waste streams at new and existing ethylene production units. (Part 63, Subpart XX)

ay. Emission standards for hazardous air pollutants: generic maximum achievable control technology (Generic MACT). These standards apply to new and existing major sources of acetal resins (AR) production, acrylic and modacrylic fiber (AMF) production, hydrogen fluoride (HF) production, polycarbonate (PC) production, carbon black production, cyanide chemicals manufacturing, ethylene production, and Spandex production. Affected processes include, but are not limited to, producers of homopolymers and copolymers of alternating oxymethylene units, acrylic fiber, modacrylic fiber synthetics composed of acrylonitrile (AN) units, hydrogen fluoride and polycarbonate. (Subpart YY)

az. to bb. Reserved.

bc. Emission standards for hazardous air pollutants for steel pickling—HCL process facilities and hydrochloric acid regeneration plants. Unless exempted, these standards apply to all new and existing major sources of hydrochloric acid process steel pickling facilities and hydrochloric acid regeneration plants. Affected processes include, but are not limited to, equipment and tanks configured for the pickling process, including the immersion, drain and rinse tanks and hydrochloric acid regeneration plants. (Subpart CCC)

bd. Emission standards for hazardous air pollutants for mineral wool production. These standards apply to all new and existing major sources of mineral wool production. Affected processes include, but are not limited to, cupolas and curing ovens. (Subpart DDD)

be. Emission standards for hazardous air pollutants from hazardous waste combustors. These standards apply to all hazardous waste combustors: hazardous waste incinerators, hazardous waste burning cement kilns, hazardous waste burning lightweight aggregate kilns, hazardous waste solid fuel boilers, hazardous waste liquid fuel boilers, and hazardous waste hydrochloric acid production furnaces, except as specified in Subpart EEE. Both area sources and major sources are subject to this subpart as of April 19, 1996, and are subject to the requirement to apply for and obtain a Title V permit. (Part 63, Subpart EEE)

bf. Reserved.

bg. Emission standards for hazardous air pollutants for pharmaceutical manufacturing. These standards apply to producers of finished dosage forms of drugs, for example, tablets, capsules, and solutions, that contain an active ingredient generally, but not necessarily, in association with inactive ingredients. Pharmaceuticals include components whose intended primary use is to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of humans or other animals. The regulations do not apply to research and development facilities. (Subpart GGG)

bh. Emission standards for hazardous air pollutants for natural gas transmission and storage. These standards apply to all new and existing major sources of natural gas transmission and storage. Natural gas transmission and storage facilities are those that transport or store natural gas prior to its entering the pipeline to a local distribution company. Affected sources include, but are not limited to, mains, valves, meters, boosters, regulators, storage vessels, dehydrators, compressors and delivery systems. (Subpart HHH)

bi. Emission standards for hazardous air pollutants for flexible polyurethane foam production. These standards apply to producers of slabstock, molded, and rebond flexible polyurethane

foam. The regulations do not apply to processes dedicated exclusively to the fabrication (i.e., gluing or otherwise bonding foam pieces together) of flexible polyurethane foam or to research and development. (Subpart III)

bj. Emission standards for hazardous air pollutants: Group IV polymers and resins. Applicable to existing and new major sources that emit organic HAP during the manufacture of the following polymers and resins: acrylonitrile butadiene styrene resin (ABS), styrene acrylonitrile resin (SAN), methyl methacrylate acrylonitrile butadiene styrene resin (MABS), methyl methacrylate butadiene styrene resin (MBS), polystyrene resin, poly (ethylene terephthalate) resin (PET), and nitrile resin. MACT is required for major sources. (Subpart JJJ)

bk. Reserved.

bl. Emission standards for hazardous air pollutants for Portland cement manufacturing operations. These standards apply to all new and existing major and area sources of Portland cement manufacturing unless exempted. Cement kiln dust (CKD) storage facilities, including CKD piles and landfills, are excluded from this standard. Affected processes include, but are not limited to, all cement kilns and in-line kiln/raw mills, unless they burn hazardous waste. (Subpart LLL)

bm. Emission standards for hazardous air pollutants for pesticide active ingredient production. These standards apply to all new and existing major sources of pesticide active ingredient production that manufacture organic pesticide active ingredients (PAI), including herbicides, insecticides and fungicides. Affected processes include, but are not limited to, processing equipment, connected piping and ducts, associated storage vessels, pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves and connectors. Exempted sources include research and development facilities, storage vessels already subject to another 40 CFR Part 63 NESHAP, production of ethylene, storm water from segregated sewers, water from fire-fighting and deluge systems (including testing of such systems) and various spills. (Subpart MMM)

bn. Emission standards for hazardous air pollutants for wool fiberglass manufacturing. These standards apply to all new and existing major sources of wool fiberglass manufacturing. Affected processes include, but are not limited to, all glass-melting furnaces, rotary spin (RS) manufacturing lines that produce bonded building insulation, flame attenuation (FA) manufacturing lines producing bonded pipe insulation and new FA manufacturing lines producing bonded heavy-density products. (Subpart NNN)

bo. Emission standards for hazardous air pollutants for amino/phenolic resins production. These standards apply to new or existing facilities that own or operate an amino or phenolic resins production unit. (Part 63, Subpart OOO)

bp. Emission standards for hazardous air pollutants for polyether polyols production. These standards apply to all new and existing major sources of polyether polyols. Polyether polyols are compounds formed through polymerization of ethylene oxide, propylene oxide or other cyclic ethers with compounds having one or more reactive hydrogens to form polyethers. Affected processes include, but are not limited to, storage vessels, process vents, heat exchange systems, equipment leaks and wastewater operations. (Subpart PPP)

bq. Emission standards for hazardous air pollutants for primary copper smelting. This standard applies to a new or existing primary copper smelter that is (or is part of) a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart QQQ)

br. Emission standards for hazardous air pollutants for secondary aluminum production. (Part 63, Subpart RRR)

bs. Reserved.

bt. Emission standards for hazardous air pollutants for primary lead smelting. These standards apply to all new and existing major sources of primary lead smelting. Affected processes include, but are not limited to, sintering machines, blast furnaces, dross furnaces and process fugitive sources. (Subpart TTT)

bu. Emission standards for hazardous air pollutants for petroleum refineries: catalytic cracking units, catalytic reforming units, and sulfur recovery units. This standard applies to a new or existing

petroleum refinery that is located at a major source of hazardous air pollutants (HAPs) emissions. (Part 63, Subpart UUU)

bv. Emission standards for hazardous air pollutants publicly owned treatment works (POTW). (Part 63, Subpart VVV)

bw. Reserved.

bx. Emission standards for hazardous air pollutants for ferroalloys production: ferromanganese and silicomanganese. These standards apply to all new and existing major sources of ferroalloys production of ferromanganese and silicomanganese. Affected processes include, but are not limited to, submerged arc furnaces, metal oxygen refining (MOR) processes, crushing and screening operations, and fugitive dust sources. (Subpart XXX)

by. to bz. Reserved.

ca. Emission standards for hazardous air pollutants: municipal solid waste landfills. This standard applies to existing and new municipal solid waste (MSW) landfills. (Part 63, Subpart AAAA)

cb. Reserved.

cc. Emission standards for hazardous air pollutants for the manufacturing of nutritional yeast. (Part 63, Subpart CCCC)

cd. Emission standards for hazardous air pollutants for plywood and composite wood products (formerly plywood and particle board manufacturing). These standards apply to new and existing major sources with equipment used to manufacture plywood and composite wood products. This equipment includes dryers, refiners, blenders, formers, presses, board coolers, and other process units associated with the manufacturing process. This also includes coating operations, on-site storage and wastewater treatment. However, only certain process units (defined in the federal rule) are subject to control or work practice requirements. (Part 63, Subpart DDDD)

ce. Emission standards for hazardous air pollutants for organic liquids distribution (non-gasoline). These standards apply to new and existing major source organic liquids distribution (non-gasoline) operations, which are carried out at storage terminals, refineries, crude oil pipeline stations, and various manufacturing facilities. (Part 63, Subpart EEEE)

cf. Emission standards for hazardous air pollutants for miscellaneous organic chemical manufacturing (MON). These standards establish emission limits and work practice standards for new and existing major sources with miscellaneous organic chemical manufacturing process units, wastewater treatment and conveyance systems, transfer operations, and associated ancillary equipment. (Part 63, Subpart FFFF)

cg. Emission standards for hazardous air pollutants for solvent extraction for vegetable oil production. (Part 63, Subpart GGGG)

ch. Emission standards for hazardous air pollutants for wet-formed fiberglass mat production. This standard applies to wet-formed fiberglass mat production plants that are major sources of hazardous air pollutants. These plants may be stand-alone facilities or located with asphalt roofing and processing facilities. (Part 63, Subpart HHHH)

ci. Emission standards for hazardous air pollutants for surface coating of automobiles and light-duty trucks. These standards apply to new, reconstructed, or existing affected sources, as defined in the standard, that are located at a facility which applies topcoat to new automobile or new light-duty truck bodies or body parts for new automobiles or new light-duty trucks and that is a major source, is located at a major source, or is part of a major source of emissions of hazardous air pollutants. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart IIII)

cj. Emission standards for hazardous air pollutants: paper and other web coating. This standard applies to a facility that is engaged in the coating of paper, plastic film, metallic foil, and other web surfaces located at a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart JJJJ)

ck. Emission standards for hazardous air pollutants for surface coating of metal cans. These standards apply to a metal can surface coating operation that uses at least 5,700 liters (1,500 gallons (gal)) of coatings per year and is a major source, is located at a major source, or is part of a major source of hazardous air pollutant emissions. Coating operations located at an area source are not subject to

this rule. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart KKKK)

cl. Reserved.

cm. Emission standards for hazardous air pollutants for surface coating of miscellaneous metal parts and products. These standards apply to miscellaneous metal parts and products surface coating facilities that are a major source, are located at a major source, or are part of a major source of hazardous air pollutant emissions. A miscellaneous metal parts and products surface coating facility that is located at an area source is not subject to this standard. Certain sources are exempt as described in the standard. (Part 63, Subpart MMMM)

cn. Emission standards for hazardous air pollutants: surface coating of large appliances. This standard applies to a facility that applies coatings to large appliance parts or products, and is a major source, is located at a major source, or is part of a major source of emissions of hazardous air pollutants (HAPs). The large appliances source category includes facilities that apply coatings to large appliance parts or products. Large appliances include “white goods” such as ovens, refrigerators, freezers, dishwashers, laundry equipment, trash compactors, water heaters, comfort furnaces, electric heat pumps and most HVAC equipment intended for any application. (Part 63, Subpart NNNN)

co. Emission standards for hazardous air pollutants for printing, coating, and dyeing of fabrics and other textiles. These standards apply to new and existing facilities with fabric or other textile coating, printing, slashing, dyeing, or finishing operations, or group of such operations, that are a major source of hazardous air pollutants or are part of a facility that is a major source of hazardous air pollutants. Coating, printing, slashing, dyeing, or finishing operations located at an area source are not subject to this standard. Several exclusions from this source category are listed in the standard. (Part 63, Subpart OOOO)

cp. Emission standards for surface coating of plastic parts and products. These standards apply to new and existing major sources with equipment used to coat plastic parts and products. The surface coating application process includes drying/curing operations, mixing or thinning operations, and cleaning operations. Coating materials include, but are not limited to, paints, stains, sealers, topcoats, basecoats, primers, inks, and adhesives. (Part 63, Subpart PPPP)

cq. Emission standards for hazardous air pollutants for surface coating of wood building products. These standards establish emission limitations, operating limits, and work practice requirements for wood building products surface coating facilities that use at least 1,100 gallons of coatings per year and are a major source, are located at a major source, or are part of a major source of hazardous air pollutant emissions. Wood building products surface coating facilities located at an area source are not subject to this standard. Several exclusions from this source category are listed in the standard. (Part 63, Subpart QQQQ)

cr. Emission standards for hazardous air pollutants: surface coating of metal furniture. This standard applies to a metal furniture surface coating facility that is a major source, is located at a major source, or is part of a major source of HAP emissions. A metal furniture surface coating facility is one that applies coatings to metal furniture or components of metal furniture. Metal furniture means furniture or components that are constructed either entirely or partially from metal. (Part 63, Subpart RRRR)

cs. Emission standards for hazardous air pollutants: surface coating of metal coil. This standard requires that all new and existing “major” air toxics sources in the metal coil coating industry meet specific emission limits. Metal coil coating is the process of applying a coating (usually protective or decorative) to one or both sides of a continuous strip of sheet metal. Industries using coated metal include: transportation, building products, appliances, can manufacturing, and packaging. Other products using coated metal coil include measuring tapes, ventilation systems for walls and roofs, lighting fixtures, office filing cabinets, cookware, and sign stock material. (Part 63, Subpart SSSS)

ct. Emission standards for hazardous air pollutants for leather finishing operations. This standard applies to a new or existing leather finishing operation that is a major source of hazardous air pollutants (HAPs) emissions or that is located at, or is part of, a major source of HAP emissions. In general, a leather finishing operation is a single process or group of processes used to adjust and improve the

physical and aesthetic characteristics of the leather surface through multistage application of a coating comprised of dyes, pigments, film-forming materials, and performance modifiers dissolved or suspended in liquid carriers. (Part 63, Subpart TTTT)

cu. Emission standards for hazardous air pollutants for cellulose products manufacturing. This standard applies to a new or existing cellulose products manufacturing operation that is located at a major source of HAP emissions. Cellulose products manufacturing includes both the miscellaneous viscose processes source category and the cellulose ethers production source category. (Part 63, Subpart UUUU)

cv. Emission standards for hazardous air pollutants for boat manufacturing. (Part 63, Subpart VVVV)

cw. Emission standards for hazardous air pollutants: reinforced plastic composites production. This standard applies to a new or an existing reinforced plastic composites production facility that is located at a major source of HAP emissions. (Part 63, Subpart WWWW)

cx. Emission standards for hazardous air pollutants: rubber tire manufacturing. This standard applies to a rubber tire manufacturing facility that is located at, or is a part of, a major source of hazardous air pollutant (HAP) emissions. Rubber tire manufacturing includes the production of rubber tires and/or the production of components integral to rubber tires, the production of tire cord, and the application of puncture sealant. (Part 63, Subpart XXXX)

cy. Emission standards for hazardous air pollutants for stationary combustion turbines. These standards apply to stationary combustion turbines which are located at a major source of hazardous air pollutant emissions. Several subcategories have been defined within the stationary combustion turbine source category. Each subcategory has distinct requirements as specified in the standards. These standards do not apply to stationary combustion turbines located at an area source of hazardous air pollutant emissions. (Part 63, Subpart YYYY)

cz. Emission standards for stationary reciprocating internal combustion engines. These standards apply to new and existing major sources with stationary reciprocating internal combustion engines (RICE). These standards also apply to new and reconstructed RICE located at area sources. For purposes of these standards, stationary RICE means any reciprocating internal combustion engine which uses reciprocating motion to convert heat energy into mechanical work and which is not mobile. (Part 63, Subpart ZZZZ)

da. Emission standards for hazardous air pollutants for lime manufacturing plants. These standards regulate hazardous air pollutant emissions from new and existing lime manufacturing plants that are major sources, are colocated with major sources, or are part of major sources. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart AAAAA)

db. Emission standards for hazardous air pollutants: semiconductor manufacturing. These standards apply to new and existing major sources with semiconductor manufacturing. (Part 63, Subpart BBBB)

dc. Emission standards for hazardous air pollutants for coke ovens: pushing, quenching, and battery stacks. This standard applies to a new or existing coke oven battery at a plant that is a major source of HAP emissions. (Part 63, Subpart CCCCC)

dd. Emission standards for industrial, commercial and institutional boilers and process heaters. These standards apply to new and existing major sources with industrial, commercial or institutional boilers and process heaters. (Part 63, Subpart DDDDD)*

*As of April 15, 2009, the adoption by reference of Part 63, Subpart DDDDD, is rescinded. On July 30, 2007, the United States Court of Appeals for the District of Columbia Circuit issued its mandate vacating 40 CFR Part 63, Subpart DDDDD, in its entirety, and requiring EPA to repromulgate final standards for industrial, commercial or institutional boilers and process heaters at new and existing major sources.

de. Emission standards for hazardous air pollutants for iron and steel foundaries. These standards apply to each new or existing iron and steel foundary that is a major source of hazardous air pollutant emissions. A new affected source is an iron and steel foundary for which construction or reconstruction

began after December 23, 2002. An existing affected source is an iron and steel foundry for which construction or reconstruction began on or before December 23, 2002. (Part 63, Subpart EEEEE)

df. Emission standards for hazardous air pollutants for integrated iron and steel manufacturing. These standards apply to affected sources at an integrated iron and steel manufacturing facility that is, or is part of, a major source of hazardous air pollutant emissions. The affected sources are each new or existing sinter plant, blast furnace, and basic oxygen process furnace (BOPF) shop at an integrated iron and steel manufacturing facility that is, or is part of, a major source of hazardous air pollutant emissions. (Part 63, Subpart FFFFF)

dg. Emission standards for hazardous air pollutants: site remediation. These standards apply to new and existing major sources with certain types of site remediation activity on the source's property or on a contiguous property. These standards control hazardous air pollutant (HAP) emissions at major sources where remediation technologies and practices are used at the site to clean up contaminated environmental media (e.g., soil, groundwater, or surface water) or certain stored or disposed materials that pose a reasonable potential threat to contaminate environmental media.

Some site remediations already regulated by rules established under the Comprehensive Environmental Response and Compensation Liability Act (CERCLA) or the Resource Conservation and Recovery Act (RCRA) are not subject to these standards, as specified in Subpart GGGGG. There are also exemptions for short-term remediation and for certain leaking underground storage tanks, as specified in Subpart GGGGG. (Part 63, Subpart GGGGG)

dh. Emission standards for hazardous air pollutants for miscellaneous coating manufacturing. These standards establish emission limits and work practice requirements for new and existing miscellaneous coating manufacturing operations, including, but not limited to, process vessels, storage tanks, wastewater, transfer operations, equipment leaks, and heat exchange systems. (Part 63, Subpart HHHHH)

di. Emission standards for mercury emissions from mercury cell chlor-alkali plants. These standards apply to the chlorine production source category. This source category contains the mercury cell chlor-alkali plant subcategory and includes all plants engaged in the manufacture of chlorine and caustic in mercury cells. These standards define two affected sources: mercury cell chlor-alkali production facilities and mercury recovery facilities. (Part 63, Subpart IIIII)

dj. Emission standards for hazardous air pollutants for brick and structural clay products manufacturing. These standards apply to new and existing brick and structural clay products manufacturing facilities that are, are located at, or are part of a major source of hazardous air pollutant emissions. (Part 63, Subpart JJJJJ)*

*As of April 15, 2009, the adoption by reference of Part 63, Subpart JJJJJ, is rescinded. On June 18, 2007, the United States Court of Appeals for the District of Columbia Circuit issued its mandate vacating 40 CFR Part 63, Subpart JJJJJ, in its entirety, and requiring EPA to repromulgate final standards for brick and structural clay products manufacturing at new and existing major sources.

dk. Emission standards for hazardous air pollutants for clay ceramics manufacturing. These standards apply to clay ceramics manufacturing facilities that are, are located at, or are part of a major source of hazardous air pollutant emissions. The clay ceramics manufacturing source category includes those facilities that manufacture pressed floor tile, pressed wall tile, and other pressed tile; or sanitaryware, such as toilets and sinks. (Part 63, Subpart KKKKK)

dl. Emission standards for hazardous air pollutants: asphalt processing and asphalt roofing manufacturing. This standard applies to an existing or new asphalt processing or asphalt roofing manufacturing facility that is a major source of hazardous air pollutants (HAPs) emissions, or is located at, or is part of a major source of HAP emissions. (Part 63, Subpart LLLLL)

dm. Emission standards for hazardous air pollutants: flexible polyurethane foam fabrication operations. This standard applies to a new or existing source at a flexible polyurethane foam fabrication facility. The standard defines two affected sources (units or collections of units to which a given standard or limit applies) corresponding to the two subcategories, loop slitter adhesive use or flame lamination. (Part 63, Subpart MMMMM)

dn. Emission standards for hazardous air pollutants: hydrochloric acid production. This standard applies to a new or existing HCl production facility that produces a liquid HCl product at a concentration of 30 weight percent or greater during its normal operations and is located at, or is part of, a major source of HAP. This does not include HCl production facilities that only occasionally produce liquid HCl product at a concentration of 30 weight percent or greater. (Part 63, Subpart NNNNN)

do. Reserved.

dp. Emission standards for hazardous air pollutants: engine test cells/stands. This standard applies to an engine test cell/stand that is located at a major source of HAP emissions. An engine test cell/stand is any apparatus used for testing uninstalled stationary or uninstalled mobile engines. (Part 63, Subpart PTTTTT)

dq. Emission standards for hazardous air pollutants for friction materials manufacturing facilities. This standard applies to a new or existing friction materials manufacturing facility that is (or is part of) a major source of hazardous air pollutants (HAPs) emissions. Friction materials manufacturing facilities produce friction materials for use in brake and clutch assemblies. (Part 63, Subpart QQQQ)

dr. Emission standards for hazardous air pollutants: taconite iron ore processing. These standards apply to new and existing taconite iron ore processing plants that are, or are part of, a major source of HAP emissions. (Part 63, Subpart RRRRR)

ds. Emission standards for hazardous air pollutants for refractory products manufacturing. This standard applies to a new or existing refractory products manufacturing facility that is, is located at, or is part of, a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart SSSSS)

dt. Emission standards for hazardous air pollutants: primary magnesium refining. These standards apply to primary magnesium refining plants that are, or are part of, a major source of HAP emissions. (Part 63, Subpart TTTTT)

du. and *dv.* Reserved.

dw. Emission standards for hazardous air pollutants for hospital ethylene oxide sterilizer area sources. This standard applies to a hospital that is an area source for hazardous air pollutant emissions and that owns or operates a new or existing ethylene oxide sterilization facility. (Part 63, Subpart WWWW)

dx. Reserved.

dy. Emission standards for hazardous air pollutants for electric arc furnace steelmaking area sources. This standard applies to new or existing electric arc furnace (EAF) steelmaking facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart YYYYY)

dz. Emission standards for hazardous air pollutants for iron and steel foundry area sources. This standard applies to new or existing iron and steel foundries that are area sources for hazardous air pollutant emissions. (Part 63, Subpart ZZZZZ)

ea. Reserved.

eb. Emission standards for hazardous air pollutants for gasoline distribution area sources: bulk terminals, bulk plants and pipeline facilities. This standard applies to new and existing bulk gasoline terminals, pipeline breakout stations, pipeline pumping stations and bulk gasoline plants that are area sources for hazardous air pollutant emissions. (Part 63, Subpart BBBBB)

ec. Emission standards for hazardous air pollutants for area sources: gasoline dispensing facilities. This standard applies to new and existing gasoline dispensing facilities (GDF) that are area sources for hazardous air pollutant emissions. The affected equipment includes each gasoline cargo tank during delivery of product to GDF and also includes each storage tank. The equipment used for refueling of motor vehicles is not covered under these standards. (Part 63, Subpart CCCCC)

ed. to *eg.* Reserved.

eh. Emission standards for hazardous air pollutants for area sources: paint stripping and miscellaneous surface coating operations. This standard applies to new or existing area sources of hazardous air pollutant emissions that engage in any of the following activities: (1) paint stripping operations that use methylene chloride (MeCl)-containing paint stripping formulations; (2) spray application of coatings to motor vehicles or mobile equipment; or (3) spray application of coatings to

plastic or metal substrate with coatings that contain compounds of chromium (Cr), lead (Pb), manganese (Mn), nickel (Ni) or cadmium (Cd). (Part 63, Subpart HHHHHH)

ei. to *ek.* Reserved.

el. *Emission standards for hazardous air pollutants for acrylic and modacrylic fibers production area sources.* This standard applies to acrylic and modacrylic fibers production plants that are area sources for hazardous air pollutant emissions. (Part 63, Subpart LLLLLL)

em. *Emission standards for hazardous air pollutants for carbon black production area sources.* This standard applies to carbon black production plants that are area sources for hazardous air pollutants. (Part 63, Subpart MMMMMM)

en. *Emission standards for hazardous air pollutants for chemical manufacturing of chromium compounds area sources.* This standard applies to plants that produce chromium compounds and are area sources for hazardous air pollutants. (Part 63, Subpart NNNNNN)

eo. *Emission standards for hazardous air pollutants for flexible polyurethane foam production and fabrication area sources.* This standard applies to plants that produce flexible polyurethane foam or rebond foam, and plants that fabricate polyurethane foam, that are area sources for hazardous air pollutants. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart OOOOOO)

ep. *Emission standards for hazardous air pollutants for lead acid battery manufacturing area sources.* This standard applies to lead acid battery manufacturing plants that are area sources for hazardous air pollutants. Affected sources include all grid casting facilities, paste mixing facilities, three-process operation facilities, lead oxide manufacturing facilities, lead reclamation facilities, and any other lead-emitting operation that is associated with a lead acid battery manufacturing plant. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart PPPPPP)

eq. *Emission standards for hazardous air pollutants for wood preserving area sources.* This standard applies to wood preserving operations that are area sources for hazardous air pollutants. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart QQQQQQ)

er. *Emission standards for hazardous air pollutants for clay ceramics manufacturing area sources.* This standard applies to any new or existing clay ceramics manufacturing facility with an atomized glaze spray booth or kiln that fires glazed ceramic ware, that processes more than 50 tons per year of wet clay, and that is an area source for hazardous air pollutant emissions. (Part 63, Subpart RRRRRR)

es. *Emission standards for hazardous air pollutants for glass manufacturing area sources.* This standard applies to any new or existing glass manufacturing facility that is an area source for hazardous air pollutant emissions and meets the following criteria: (1) manufactures flat glass, glass containers or pressed and blown glass by melting a mixture of raw materials to produce molten glass and form the molten glass into sheets, containers or other shapes; and (2) uses one or more continuous furnaces to produce glass at a rate of at least 50 tons per year and that contains compounds of one or more "glass manufacturing metal HAP," as defined in 40 CFR 63.11459, as raw materials in a glass manufacturing batch formulation. (Part 63, Subpart SSSSSS)

et. *Emissions standards for hazardous air pollutants for secondary nonferrous metals processing area sources.* This standard applies to any new or existing secondary nonferrous metals processing facility that is an area source for hazardous air pollutant emissions. This standard applies to all crushing and screening operations at a secondary zinc processing facility and to all furnace melting operations located at any secondary nonferrous metals processing facility. (Part 63, Subpart TTTTTT)

eu. Reserved.

ev. Emission standards for hazardous air pollutants for area sources: chemical manufacturing. This standard applies to chemical manufacturing at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart VVVVVV)

ew. Emission standards for hazardous air pollutants for area sources: plating and polishing. This standard applies to plating and polishing activities at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart WWWWWW)

ex. Emission standards for hazardous air pollutants for area sources: metal fabrication and finishing. This standard applies to new and existing facilities in which the primary activity or activities at the facility are metal fabrication and finishing and that are area sources for hazardous air pollutant emissions. (Part 63, Subpart XXXXXX)

fa. and fb. Reserved.

fc. Emission standards for hazardous air pollutants for area sources: paint and allied products manufacturing. This standard applies to paint and allied products manufacturing at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart CCCCCC)

fd. Emission standards for hazardous air pollutants for area sources: prepared feeds manufacturing. This standard applies to prepared feeds manufacturing that produces animal feed products (not including feed for cats or dogs) and uses chromium or manganese compounds at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart DDDDDDD)

23.1(5) Emission guidelines. The emission guidelines and compliance times for existing sources, as defined in 40 Code of Federal Regulations Part 60 as amended through June 9, 2006, shall apply to the following affected facilities. The corresponding 40 CFR Part 60 subpart designation is in parentheses. The control of the designated pollutants will be in accordance with federal standards established in Sections 111 and 129 of the Act and 40 CFR Part 60, Subpart B (Adoption and Submittal of State Plans for Designated Facilities), and the applicable subpart(s) for the existing source. Reference test methods (Appendix A), performance specifications (Appendix B), determination of emission rate change (Appendix C), quality assurance procedures (Appendix F) and the general provisions (Subpart A) of 40 CFR Part 60 also apply to the affected facilities.

a. Emission guidelines for municipal solid waste landfills (Subpart Cc). Emission guidelines and compliance times for the control of certain designated pollutants from designated municipal solid waste landfills shall be in accordance with federal standards established in Subparts Cc (Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills) and WWW (Standards of Performance for Municipal Solid Waste Landfills) of 40 CFR Part 60.

(1) Definitions. For the purpose of 23.1(5)“a,” the definitions have the same meaning given to them in the Act and 40 CFR Part 60, Subparts A (General Provisions), B, and WWW, if not defined in this subparagraph.

“Municipal solid waste landfill” or “MSW landfill” means an entire disposal facility in a contiguous geographical space where household waste is placed in or on land. An MSW landfill may also receive other types of RCRA Subtitle D wastes such as commercial solid waste, nonhazardous sludge, and industrial solid waste. Portions of an MSW landfill may be separated by access roads. An MSW landfill may be publicly or privately owned. An MSW landfill may be a new MSW landfill, an existing MSW landfill or a lateral expansion.

(2) Designated facilities.

1. The designated facility to which the emission guidelines apply is each existing MSW landfill for which construction, reconstruction or modification was commenced before May 30, 1991.

2. Physical or operational changes made to an existing MSW landfill solely to comply with an emission guideline are not considered a modification or reconstruction and would not subject an existing MSW landfill to the requirements of 40 CFR Part 60, Subpart WWW (40 CFR 60.750).

3. For MSW landfills subject to rule 567—22.101(455B) only because of applicability to subparagraph 23.1(5)“a”(2), the following apply for obtaining and maintaining a Title V operating permit under 567—22.104(455B):

The owner or operator of an MSW landfill with a design capacity less than 2.5 million megagrams or 2.5 million cubic meters is not required to obtain an operating permit for the landfill.

The owner or operator of an MSW landfill with a design capacity greater than or equal to 2.5 million megagrams and 2.5 million cubic meters on or before June 22, 1998, becomes subject to the requirements of 567—subrule 22.105(1) on September 20, 1998. This requires the landfill to submit a Title V permit application to the Air Quality Bureau, Department of Natural Resources, no later than September 20, 1999.

The owner or operator of a closed MSW landfill does not have to maintain an operating permit for the landfill if either of the following conditions are met: the landfill was never subject to the requirement for a control system under subparagraph 23.1(5)“a”(3); or the owner or operator meets the conditions for control system removal specified in 40 CFR § 60.752(b)(2)(v).

(3) Emission guidelines for municipal solid waste landfill emissions.

1. MSW landfill emissions at each MSW landfill meeting the conditions below shall be controlled. A design capacity report must be submitted to the director by November 18, 1997.

The landfill has accepted waste at any time since November 8, 1987, or has additional design capacity available for future waste deposition.

The landfill has a design capacity greater than or equal to 2.5 million megagrams or 2.5 million cubic meters. The landfill may calculate design capacity in either megagrams or cubic meters for comparison with the exemption values. Any density conversions shall be documented and submitted with the report. All calculations used to determine the maximum design capacity must be included in the design capacity report.

The landfill has a nonmethane organic compound (NMOC) emission rate of 50 megagrams per year or more. If the MSW landfill’s design capacity exceeds the established thresholds in 23.1(5)“a”(3)“1,” the NMOC emission rate calculations must be provided with the design capacity report.

2. The planning and installation of a collection and control system shall meet the conditions provided in 40 CFR 60.752(b)(2) at each MSW landfill meeting the conditions in 23.1(5)“a”(3)“1.”

3. MSW landfill emissions collected through the use of control devices must meet the following requirements, except as provided in 40 CFR 60.24 after approval by the Director and U.S. Environmental Protection Agency.

An open flare designed and operated in accordance with the parameters established in 40 CFR 60.18; a control system designed and operated to reduce NMOC by 98 weight percent; or an enclosed combustor designed and operated to reduce the outlet NMOC concentration to 20 parts per million as hexane by volume, dry basis at 3 percent oxygen, or less.

(4) Test methods and procedures. The following must be used:

1. The calculation of the landfill NMOC emission rate listed in 40 CFR 60.754, as applicable, to determine whether the landfill meets the condition in 23.1(5)“a”(3)“3”;

2. The operational standards in 40 CFR 60.753;

3. The compliance provisions in 40 CFR 60.755; and

4. The monitoring provisions in 40 CFR 60.756.

(5) Reporting and record-keeping requirements. The record-keeping and reporting provisions listed in 40 CFR 60.757 and 60.758, as applicable, except as provided under 40 CFR 60.24 after approval by the Director and U.S. Environmental Protection Agency, shall be used.

(6) Compliance times.

1. Except as provided for under 23.1(5)“a”(6)“2,” planning, awarding of contracts, and installation of MSW landfill air emission collection and control equipment capable of meeting the emission guidelines established under 23.1(5)“a”(3) shall be accomplished within 30 months after the date the initial NMOC emission rate report shows NMOC emissions greater than or equal to 50 megagrams per year.

2. For each existing MSW landfill meeting the conditions in 23.1(5)“a”(3)“1” whose NMOC emission rate is less than 50 megagrams per year on August 20, 1997, installation of collection and control systems capable of meeting emission guidelines in 23.1(5)“a”(3) shall be accomplished within

30 months of the date when the condition in 23.1(5) “a”(3)“1” is met (i.e., the date of the first annual nonmethane organic compounds emission rate which equals or exceeds 50 megagrams per year).

b. Emission guidelines for hospital/medical/infectious waste incinerators (Subpart Ce). This paragraph contains emission guidelines and compliance times for the control of certain designated pollutants from hospital/medical/infectious waste incinerator(s) (HMIWI) in accordance with Subparts Ce and Ec (Standards of Performance for Hospital/Medical/Infectious Waste Incinerators) of 40 CFR Part 60.*

*As of November 24, 2010, the emission guidelines for hospital/medical/infectious waste incinerators (Subpart Ce) are rescinded.

c. Emission guidelines and compliance schedules for commercial and industrial solid waste incineration units that commenced construction on or before November 30, 1999. Emission guidelines and compliance schedules for the control of designated pollutants from affected commercial and industrial solid waste incinerators that commenced construction on or before November 30, 1999, shall be in accordance with federal plan requirements established in Subpart III of 40 CFR Part 62.

d. Emission guidelines for mercury for coal-fired electric utility steam generating units. Rescinded IAB 10/7/09, effective 11/11/09.

23.1(6) Calculation of emission limitations based upon stack height. This rule sets limits for the maximum stack height credit to be used in ambient air quality modeling for the purpose of setting an emission limitation and calculating the air quality impact of a source. The rule does not limit the actual physical stack height for any source.

For the purpose of this subrule, definitions of “stack,” “a stack in existence,” “dispersion technique,” “nearby” and “excessive concentration” as set forth in 40 CFR §§ 51.100(ff) through (hh), (jj) and (kk) as amended through June 14, 1996, are adopted by reference.

a. “Good engineering practice (GEP) stack height” means the greater of:

- (1) Sixty-five meters, measured from the ground level elevation at the base of the stack; or
- (2) For stacks in existence on January 12, 1979, and for which the owner and operator had obtained all applicable permits or approvals required under 567—Chapter 22 and 40 CFR § 52.21 as amended through June 13, 2007,

$$H_g = 2.5H$$

provided the owner or operator produces evidence that this equation was actually relied on in establishing an emission limitation;

For all other stacks,

$$H_g = H + 1.5L$$

where:

H_g = good engineering practice stack height, measured from the ground level elevation at the base of the stack,

H = height of nearby structure(s) measured from the ground level elevation at the base of the stack,

L = lesser dimension, height or projected width, of nearby structure(s), provided that the department may require the use of a field study or fluid model to verify GEP stack height for the source; or

(3) The height demonstrated by a fluid model or a field study approved by the department, which ensures that the emissions from a stack do not result in excessive concentrations of any air pollutant as a result of atmospheric downwash, wakes, or eddy effects created by the source itself, nearby structures or nearby terrain features. Public notification of the availability of such study and opportunity for public hearing are required prior to approval by the department.

b. The degree of emission limitation required for control of any air contaminant under this chapter shall not be affected in any manner by:

- (1) The consideration of that portion of a stack which exceeds GEP stack height; or
- (2) Varying the rate of emission of a pollutant according to atmospheric conditions or ambient concentrations of that pollutant; or

(3) Increasing final exhaust gas plume rise by manipulating source process parameters, exhaust gas parameters, stack parameters, or combined exhaust gases from several existing stacks into one stack; or other selective handling of exhaust gas streams so as to increase gas plume rise.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 7565B, IAB 2/11/09, effective 3/18/09; ARC 7623B, IAB 3/11/09, effective 4/15/09; ARC 8216B, IAB 10/7/09, effective 11/11/09; ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 9154B, IAB 10/20/10, effective 11/24/10 (See Delay note at end of chapter) (See Rescission note at end of chapter)]

567—23.2(455B) Open burning.

23.2(1) Prohibition. No person shall allow, cause or permit open burning of combustible materials, except as provided in 23.2(2) and 23.2(3).

23.2(2) Variances from rules. Any person wishing to conduct open burning of materials not exempted in 23.2(3) may make application for a variance as specified in 567—subrule 21.2(1). In addition to requiring the information specified under 567—subrule 21.2(1), the director may require any person applying for a variance from the open burning rules to submit adequate documentation to allow the director to assess whether granting the variance will hinder attainment or maintenance of a National Ambient Air Quality Standard (NAAQS).

23.2(3) Exemptions. The open burning exemptions specified in this subrule shall not be construed as exemptions from any other applicable environmental regulations. In particular, the exemptions contained in this subrule do not absolve any person from compliance with the rules for solid waste disposal, including ash disposal, and solid waste permitting contained in 567—Chapters 100 through 130 or the rules for storm water runoff and storm water permitting contained in 567—Chapters 60 and 64. The following shall be permitted unless prohibited by local ordinances or regulations.

a. Disaster rubbish. The open burning of rubbish, including landscape waste, for the duration of the community disaster period in cases where an officially declared emergency condition exists. Burning of any structures or demolished structures shall be conducted in accordance with 40 CFR Section 61.145 as amended through January 16, 1991, which is the “Standard for Demolition and Renovation” of the asbestos National Emission Standard for Hazardous Air Pollutants.

b. Trees and tree trimmings. The open burning of trees and tree trimmings not originated on the premises provided that the burning site is operated by a local governmental entity, the burning site is fenced and access is controlled, burning is conducted on a regularly scheduled basis and is supervised at all times, burning is conducted only when weather conditions are favorable with respect to surrounding property, and the burning site is limited to areas at least one-quarter mile from any inhabited building unless a written waiver in the form of an affidavit is submitted by the owner of the building to the department and to the local governmental entity prior to the first instance of open burning at the site which occurs after November 13, 1996. The written waiver shall become effective only upon recording in the office of the recorder of deeds of the county in which the inhabited building is located. However, when the open burning of trees and tree trimmings causes air pollution as defined in Iowa Code section 455B.131(3), the department may take appropriate action to secure relocation of the burning operation. Rubber tires shall not be used to ignite trees and tree trimmings.

This exemption shall not apply within the area classified as the PM10 (inhalable) particulate Group II area of Mason City. This Group II area is described as follows: the area in Cerro Gordo County, Iowa, in Lincoln Township including Sections 13, 24 and 25; in Lime Creek Township including Sections 18, 19, 20, 21, 27, 28, 29, 30, 31, 32, 33, 34 and 35; in Mason Township the W ½ of Section 1, Sections 2, 3, 4, 5, 8, 9, the N ½ of Section 11, the NW ¼ of Section 12, the N ½ of Section 16, the N ½ of Section 17 and the portions of Sections 10 and 15 north and west of the line from U.S. Highway 18 south on Kentucky Avenue to 9th Street SE; thence west on 9th Street SE to the Minneapolis and St. Louis railroad tracks; thence south on Minneapolis and St. Louis railroad tracks to 19th Street SE; thence west on 19th Street SE to the section line between Sections 15 and 16.

c. Flare stacks. The open burning or flaring of waste gases, providing such open burning or flaring is conducted in compliance with 23.3(2) “d” and 23.3(3) “e.”

d. Landscape waste. The disposal by open burning of landscape waste originating on the premises. However, the burning of landscape waste produced in clearing, grubbing and construction operations

shall be limited to areas located at least one-fourth mile from any building inhabited by other than the landowner or tenant conducting the open burning. Rubber tires shall not be used to ignite landscape waste.

e. Recreational fires. Open fires for cooking, heating, recreation and ceremonies, provided they comply with 23.3(2) “d.” Burning rubber tires is prohibited from this activity.

f. Residential waste. Backyard burning of residential waste at dwellings of four-family units or less. The adoption of more restrictive ordinances or regulations of a governing body of the political subdivision, relating to control of backyard burning, shall not be precluded by these rules.

g. Training fires. For purposes of subrule 23.2(3), a “training fire” is a fire set for the purposes of conducting bona fide training of public or industrial employees in firefighting methods. For purposes of this paragraph, “bona fide training” means training that is conducted according to the National Fire Protection Association 1403 Standard of Live Fire Training Evolutions (2002 Edition) or a comparable training fire standard. A training fire may be conducted, provided that all of the following conditions are met:

(1) A training fire on a building is conducted with the building structurally intact.

(2) The training fire does not include the controlled burn of a demolished building.

(3) If the training fire is to be conducted on a building, written notification is provided to the department on DNR Form 542-8010, Notification of an Iowa Training Fire-Demolition or a Controlled Burn of a Demolished Building, and is postmarked or delivered to the director at least ten working days before such action commences.

(4) Notification shall be made in accordance with 40 CFR Section 61.145, “Standard for Demolition and Renovation” of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991.

(5) All asbestos-containing materials shall be removed prior to the training fire.

(6) Asphalt roofing may be burned in the training fire only if notification to the director contains testing results indicating that none of the layers of asphalt roofing contain asbestos. During each calendar year, each fire department may conduct no more than two training fires on buildings where asphalt roofing has not been removed, provided that for each of those training fires the asphalt roofing material present has been tested to ensure that it does not contain asbestos. Each fire department’s limit on the burning of asphalt roofing shall include both training fires and the controlled burning of a demolished building, as specified in 23.2(3) “j.”

(7) Rubber tires shall not be burned during a training fire.

h. Paper or plastic pesticide containers and seed corn bags. The disposal by open burning of paper or plastic pesticide containers (except those formerly containing organic forms of beryllium, selenium, mercury, lead, cadmium or arsenic) and seed corn bags resulting from farming activities occurring on the premises. Such open burning shall be limited to areas located at least one-fourth mile from any building inhabited by other than the landowner or tenant conducting the open burning, livestock area, wildlife area, or water source. The amount of paper or plastic pesticide containers and seed corn bags that can be disposed of by open burning shall not exceed one day’s accumulation or 50 pounds, whichever is less. However, when the burning of paper or plastic pesticide containers or seed corn bags causes a nuisance, the director may take action to secure relocation of the burning operation. Since the concentration levels of pesticide combustion products near the fire may be hazardous, the person conducting the open burning should take precautions to avoid inhalation of the pesticide combustion products.

i. Agricultural structures. The open burning of agricultural structures, provided that the open burning occurs on the premises and, for agricultural structures located within a city or town, at least one-fourth mile from any building inhabited by a person other than the landowner, a tenant, or an employee of the landowner or tenant conducting the open burning unless a written waiver in the form of an affidavit is submitted by the owner of the building to the department prior to the open burning; all chemicals and asphalt roofing are removed; burning is conducted only when weather conditions are favorable with respect to surrounding property; and permission from the local fire chief is secured in advance of the burning. Rubber tires shall not be used to ignite agricultural structures. The asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January

16, 1991, requires the burning of agricultural structures to be conducted in accordance with 40 CFR Section 61.145, "Standard for Demolition and Renovation."

For the purposes of this subrule, "agricultural structures" means barns, machine sheds, storage cribs, animal confinement buildings, and homes located on the premises and used in conjunction with crop production, livestock or poultry raising and feeding operations. "Agricultural structures," for asbestos NESHAP purposes, includes all of the above, with the exception of a single residential structure on the premises having four or fewer dwelling units, which has been used only for residential purposes.

j. Controlled burning of a demolished building. A city, as "city" is defined in Iowa Code section 362.2(4), with approval of its council, as "council" is defined in Iowa Code section 362.2(8), may conduct a controlled burn of a demolished building. A city is the only party that may conduct such a burn and is responsible for ensuring that all of the following conditions are met:

(1) *Prohibition.* The controlled burning of a demolished building is prohibited within the city limits of Cedar Rapids, Marion, Hiawatha, Council Bluffs, Carter Lake, Des Moines, West Des Moines, Clive, Windsor Heights, Urbandale, Pleasant Hill, Buffalo, Davenport, Mason City or any other area where area-specific state implementation plans require the control of particulate matter.

(2) *Notification requirements.* For each building proposed to be burned, the city fire department or a city official, on behalf of the city, shall submit to the department a completed notification postmarked at least 10 working days prior to commencing demolition and at least 30 days before the proposed controlled burn commences. Documentation of city council approval shall be submitted with the notification. Information required to be provided shall include: the exact location of the burn site; the approximate distance to the nearest neighboring residence or business; the method used by the city to notify nearby residents of the proposed burn; an explanation of why alternative methods of demolition debris management are not being used; and information required by 40 CFR Section 61.145, "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991. Notification shall be provided on DNR Form 542-8010, Notification of an Iowa Training Fire-Demolition or a Controlled Burn of a Demolished Building. For burns conducted outside the city limits, the city shall send to the chairperson of the applicable county board a copy of the completed DNR notification form 542-8010 and documentation of city council approval. Notification to the county board shall be postmarked, faxed or sent by electronic mail at least 30 days before the proposed controlled burn commences.

(3) *Asbestos removal requirements.* All asbestos-containing materials shall be removed before the building to be burned is demolished. The department may require proof that any applicable inspection, notification, removal and demolition occurred, or will occur, in accordance with 40 CFR Section 61.145, "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991.

(4) *Requirements for asphalt roofing.* During each calendar year, each city shall conduct no more than two controlled burns of a demolished building in which asphalt roofing has not been removed, provided that for each controlled burn of a demolished building the asphalt roofing material present has been tested to ensure that it does not contain asbestos. Each city's limit on the burning of asphalt roofing shall include both the controlled burning of a demolished building and training fires, as specified in paragraph 23.2(3)"g."

(5) *Building size limit.* For each proposed controlled burn located within the city limits, more than one demolished building may be included in the burn, provided that the sum total of all building material to be burned at a designated site does not exceed 1700 square feet in size. For a controlled burn site located outside the city limits, the sum total of all building material to be burned, per day, may not exceed 1700 square feet in size. For purposes of this subparagraph, "square feet" includes both finished and unfinished basements and excludes unfinished attics, carports, attached garages, and porches that are not protected from weather.

(6) *Time of day requirements.* The controlled burning of a demolished building may be conducted only between the hours of 6 a.m. and 6 p.m. and only when weather conditions are favorable with respect to surrounding property. The city shall adequately schedule and sufficiently control the burn to ensure that burning is completed by 6 p.m.

(7) *Prohibited materials.* Rubber tires, chemicals, furniture, carpeting, household appliances, vinyl products (such as flooring or siding), trade waste, garbage, rubbish, landscape waste, residential waste, and other nonstructural materials shall not be burned.

(8) *Limits on the number and location of burns.* For burns conducted within the city limits, each city may undertake no more than one controlled burn of demolished building material in every 0.6-mile-radius circle during each calendar year. For burn sites established outside the city limits, each city shall undertake no more than one controlled burn of demolished building material per day. A burn site outside the city limits must be located at least 0.6 of a mile from any building inhabited by a person, as “person” is defined in Iowa Code section 362.2(17).

(9) *Requirements for burn access and supervision.* The city shall control access to all demolished building burn sites. Representatives of the city who are city employees or who are hired by the city shall supervise the burning of demolished building material at all times.

(10) *Record-keeping requirements.* The city shall retain at least one copy of all notifications and supplementary information required to be sent to the department under subparagraph (2). Additionally, the city shall maintain a map of the exact location of each burn site, and supporting documentation showing the date of each demolished building burn and the square feet of building material burned on each date. All maps, notifications and associated records shall be maintained by the city clerk, as “clerk” is defined in Iowa Code section 362.2(7), for a period of at least three years and shall be made available for inspection by the department upon request.

(11) *Variance from this paragraph.* In accordance with 567—subrules 21.2(1) and 23.2(2), a city may apply for a variance from the specific conditions for controlled burning of a demolished building and may request that the director conduct a review of the ambient air impacts of the request. The director shall approve or deny the request in accordance with 567—subrule 21.2(4).

(12) *Compliance with other applicable environmental regulations.* Compliance with the exemption requirements in this paragraph shall not absolve a city of the responsibility to comply with any other applicable environmental regulations. In particular, a city conducting a controlled burn of a demolished building shall comply with all applicable solid waste disposal, including ash disposal, and solid waste permitting rules contained in 567—Chapters 100 through 130, as well as all applicable storm water discharge and storm water permitting rules contained in 567—Chapters 60 and 64.

23.2(4) Unavailability of exemptions in certain areas. Notwithstanding 23.2(2) and 23.2(3) “b,” “d,” “f,” and “i,” no person shall allow, cause or permit the open burning of trees or tree trimmings, residential or landscape waste or agricultural structures in the cities of: Cedar Rapids, Marion, Hiawatha, Council Bluffs, Carter Lake, Des Moines, West Des Moines, Clive, Windsor Heights, Urbandale, and Pleasant Hill.

This rule is intended to implement Iowa Code section 455B.133.

567—23.3(455B) Specific contaminants.

23.3(1) General. The emission standards contained in this rule shall apply to each source operation unless a specific emission standard for the process involved is prescribed elsewhere in this chapter, in which case the specific standard shall apply.

23.3(2) Particulate matter. No person shall cause or allow the emission of particulate matter from any source in excess of the emission standards specified in this chapter, except as provided in 567—Chapter 24.

a. General emission rate.

(1) For sources constructed, modified or reconstructed on or after July 21, 1999, the emission of particulate matter from any process shall not exceed an emission standard of 0.1 grain per dry standard cubic foot (dscf) of exhaust gas, except as provided in 567—21.2(455B), 23.1(455B), 23.4(455B), and 567—Chapter 24.

(2) For sources constructed, modified or reconstructed prior to July 21, 1999, the emission of particulate matter from any process shall not exceed the amount determined from Table I, or amount specified in a permit if based on an emission standard of 0.1 grain per standard cubic foot of exhaust gas, or established from standards provided in 23.1(455B) and 23.4(455B).

TABLE I
ALLOWABLE RATE OF EMISSION BASED ON PROCESS WEIGHT RATE*

Process Weight Rate		Emission Rate	Process Weight Rate		Emission Rate
Lb/Hr	Tons/Hr	Lb/Hr	Lb/Hr	Tons/Hr	Lb/Hr
100	0.05	0.55	16,000	8.00	16.5
200	0.10	0.88	18,000	9.00	17.9
400	0.20	1.40	20,000	10.00	19.2
600	0.30	1.83	30,000	15.00	25.2
800	0.40	2.22	40,000	20.00	30.5
1,000	0.50	2.58	50,000	25.00	35.4
1,500	0.75	3.38	60,000	30.00	40.0
2,000	1.00	4.10	70,000	35.00	41.3
2,500	1.25	4.76	80,000	40.00	42.5
3,000	1.50	5.38	90,000	45.00	43.6
3,500	1.75	5.96	100,000	50.00	44.6
4,000	2.00	6.52	120,000	60.00	46.3
5,000	2.50	7.58	140,000	70.00	47.8
6,000	3.00	8.56	160,000	80.00	49.0
7,000	3.50	9.49	200,000	100.00	51.2
8,000	4.00	10.4	1,000,000	500.00	69.0
9,000	4.50	11.2	2,000,000	1,000.00	77.6
10,000	5.00	12.0	6,000,000	3,000.00	92.7
12,000	6.00	13.6			

*Interpolation of the data in this table for process weight rates up to 60,000 lb/hr shall be accomplished by the use of the equation

$$E=4.10 P^{0.67},$$

and interpolation and extrapolation of the data for process weight rates in excess of 60,000 lb/hr shall be accomplished by use of the equation

$$E=55.0 P^{0.11}-40,$$

where E = rate of emission in lb/hr, and

P = process weight in tons/hr

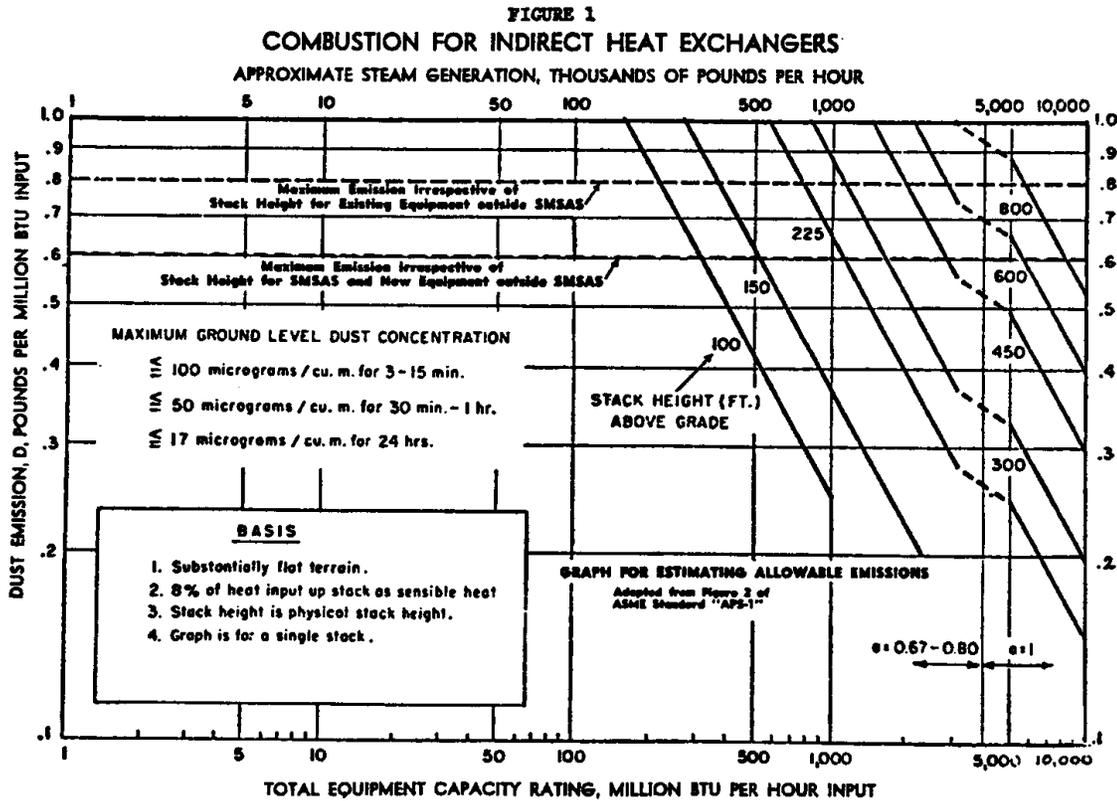
b. Combustion for indirect heating. Emissions of particulate matter from the combustion of fuel for indirect heating or for power generation shall be limited by the ASME Standard APS-1, Second Edition, November, 1968, "Recommended Guide for the Control of Dust Emission—Combustion for Indirect Heat Exchangers." For the purpose of this paragraph, the allowable emissions shall be calculated from equation (15) in that standard, with $Comax^2=50$ micrograms per cubic meter. Allowable emissions from a single stack may be estimated from Figure 1. The maximum ground level dust concentrations designated are above the background level. For plants with 4,000 million Btu/hour input or more, the "a" factor shall be 1.0. In plants with less than 4,000 million Btu/hour input, appropriate "a" factors, less than 1.0, shall be applied. Pertinent correction factors, as specified in the standard, shall be applied for installations with multiple stacks. However, for fuel-burning units in operation on January 13, 1976, the maximum allowable emissions calculated under APS-1 for the facility's equipment configuration on January 13, 1976, shall not be increased even if the changes in the equipment or stack configuration would otherwise allow a recalculation and a higher maximum allowable emission under APS-1.

(1) Outside any standard metropolitan statistical area, the maximum allowable emissions from each stack, irrespective of stack height, shall be 0.8 pounds of particulates per million Btu input.

(2) Inside any standard metropolitan statistical area, the maximum allowable emission from each stack, irrespective of stack height, shall be 0.6 pounds of particulates per million Btu input.

(3) For a new fossil fuel-fired steam generating unit of more than 250 million Btu per hour heat input, 23.1(2) "a" shall apply. For a new unit of between 150 million and 250 million (inclusive) Btu per hour heat input, the maximum allowable emissions from such new unit shall be 0.2 pounds of particulates per million Btu of heat input. For a new unit of less than 150 million Btu per hour heat input, the maximum allowable emissions from such new unit shall be 0.6 pounds of particulates per million Btu of heat input.

(4) Measurements of emissions from a particulate source will be made in accordance with the provisions of 567—Chapter 25.



(5) For fuel-burning sources in operation prior to July 29, 1977, which are not subject to 23.1(2) and which significantly impact a primary or secondary particulate standard nonattainment area, the emission limitations specified in this subparagraph apply. A significant impact shall be equal to or exceeding 5 micrograms of particulate matter per cubic meter of air (24-hour average) or 1 microgram of particulate matter per cubic meter of air (annual average) determined by an EPA approved single source dispersion model using allowable emission rates and five-year worst case meteorological conditions. In the case where two or more boilers discharge into a common stack, the applicable stack emission limitation shall be based upon the heat input of the largest operating boiler. The plantwide allowable emission limitation shall be the weighted average of the allowable emission limitations for each stack or the applicable APS-1 plantwide standard as determined under paragraph 23.3(2) "b," whichever is more stringent.

The maximum allowable emission rate for a single stack with a total heat input capacity less than 250 million Btu per hour shall be 0.60 pound of particulate matter per million Btu heat input; the maximum allowable emission rate for a single stack with a total heat input capacity greater than or equal to 250 million Btu per hour and less than 500 million Btu per hour shall be 0.40 pound of particulate matter per million Btu heat input; the maximum allowable emission rate for a single stack with a total heat input capacity greater than or equal to 500 million Btu per hour shall be 0.30 pound of particulate matter per

million Btu heat input; except that the maximum allowable emission rate for the stack serving Unit #1 of Iowa Public Service at Port Neal shall be 0.50 pound of particulate matter per million Btu heat input.

All sources regulated under this subparagraph shall demonstrate compliance by October 1, 1981; however, a source is considered to be in compliance with this subparagraph if by October 1, 1981, it is on a compliance schedule to be completed as expeditiously as possible, but no later than December 31, 1982.

c. Fugitive dust.

(1) Attainment and unclassified areas. A person shall take reasonable precautions to prevent particulate matter from becoming airborne in quantities sufficient to cause a nuisance as defined in Iowa Code section 657.1 when the person allows, causes or permits any materials to be handled, transported or stored or a building, its appurtenances or a construction haul road to be used, constructed, altered, repaired or demolished, with the exception of farming operations or dust generated by ordinary travel on unpaved roads. Ordinary travel includes routine traffic and road maintenance activities such as scarifying, compacting, transporting road maintenance surfacing material, and scraping of the unpaved public road surface. All persons, with the above exceptions, shall take reasonable precautions to prevent the discharge of visible emissions of fugitive dusts beyond the lot line of the property on which the emissions originate. The public highway authority shall be responsible for taking corrective action in those cases where said authority has received complaints of or has actual knowledge of dust conditions which require abatement pursuant to this subrule. Reasonable precautions may include, but not be limited to, the following procedures.

1. Use, where practical, of water or chemicals for control of dusts in the demolition of existing buildings or structures, construction operations, the grading of roads or the clearing of land.

2. Application of suitable materials, such as but not limited to asphalt, oil, water or chemicals on unpaved roads, material stockpiles, race tracks and other surfaces which can give rise to airborne dusts.

3. Installation and use of containment or control equipment, to enclose or otherwise limit the emissions resulting from the handling and transfer of dusty materials, such as but not limited to grain, fertilizer or limestone.

4. Covering, at all times when in motion, open-bodied vehicles transporting materials likely to give rise to airborne dusts.

5. Prompt removal of earth or other material from paved streets or to which earth or other material has been transported by trucking or earth-moving equipment, erosion by water or other means.

6. Reducing the speed of vehicles traveling over on-property surfaces as necessary to minimize the generation of airborne dusts.

(2) Nonattainment areas. Subparagraph (1) notwithstanding, no person shall allow, cause or permit any visible emission of fugitive dust in a nonattainment area for particulate matter to go beyond the lot line of the property on which a traditional source is located without taking reasonable precautions to prevent emission. Traditional source means a source category for which a particulate emission standard has been established in 23.1(2), 23.3(2) "a," 23.3(2) "b" or 23.4(455B) and includes a quarry operation, haul road or parking lot associated with a traditional source. This paragraph does not modify the emission standard stated in 23.1(2), 23.3(2) "a," 23.3(2) "b" or 23.4(455B), but rather establishes a separate requirement for fugitive dust from such sources. For guidance on the types of controls which may constitute reasonable precautions, see "Identification of Techniques for the Control of Industrial Fugitive Dust Emissions," [available from the department] adopted by the commission on May 19, 1981.

(3) Reclassified areas. Reasonable precautions implemented pursuant to the nonattainment area provisions of subparagraph (2) shall remain in effect if the nonattainment area is redesignated to either attainment or unclassified after March 6, 1980.

d. Visible emissions. No person shall allow, cause or permit the emission of visible air contaminants into the atmosphere from any equipment, internal combustion engine, premise fire, open fire or stack, equal to or in excess of 40 percent opacity or that level specified in a construction permit, except as provided below and in 567—Chapter 24.

(1) *Residential heating equipment.* Residential heating equipment serving dwellings of four family units or less is exempt.

(2) *Gasoline-powered vehicles.* No person shall allow, cause or permit the emission of visible air contaminants from gasoline-powered motor vehicles for longer than five consecutive seconds.

(3) *Diesel-powered vehicles.* No person shall allow, cause or permit the emission of visible air contaminants from diesel-powered motor vehicles in excess of 40 percent opacity, for longer than five consecutive seconds.

(4) *Diesel-powered locomotives.* No person shall allow, cause or permit the emission of visible air contaminants from diesel-powered locomotives in excess of 40 percent opacity, except for a maximum period of 40 consecutive seconds during acceleration under load, or for a period of four consecutive minutes when a locomotive is loaded after a period of idling.

(5) *Startup and testing.* Initial start and warmup of a cold engine, the testing of an engine for trouble, diagnosis or repair, or engine research and development activities, is exempt.

(6) *Uncombined water.* The provisions of this paragraph shall apply to any emission which would be in violation of these provisions except for the presence of uncombined water, such as condensed water vapor.

23.3(3) Sulfur compounds. The provisions of this subrule shall apply to any installation from which sulfur compounds are emitted into the atmosphere.

a. Sulfur dioxide from use of solid fuels.

(1) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from an existing solid fuel-burning unit, (i.e., a unit which was in operation or for which components had been purchased, or which was under construction prior to September 23, 1970), in an amount greater than 6 pounds, replicated maximum three-hour average, per million Btu of heat input if such unit is located within the following counties: Black Hawk, Clinton, Des Moines, Dubuque, Jackson, Lee, Linn, Lousia, Muscatine and Scott.

(2) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from an existing solid fuel-burning unit, (i.e., a unit which was in operation or for which components had been purchased, or which was under construction prior to September 23, 1970), in an amount greater than 5 pounds, replicated maximum three-hour average, per million Btu of heat input if such unit is located within the remaining 89 counties of the state not listed in subparagraph 23.3(3) "a"(1).

(3) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from any new solid fuel-burning unit (i.e., a unit which was not in operation or for which components had not been purchased, or which was not under construction prior to September 23, 1970) which has a capacity of 250 million Btu or less per hour heat input, in an amount greater than 6 pounds, replicated maximum three-hour average, per million Btu of heat input.

(4) Subparagraphs (1) through (3) notwithstanding, a fossil fuel-fired steam generator to which 23.1(2) "a," 23.1(2) "z" or 23.1(2) "ccc" applies shall comply with 23.1(2) "a," 23.1(2) "z" or 23.1(2) "ccc," respectively.

b. Sulfur dioxide from use of liquid fuels.

(1) No person shall allow, cause, or permit the combustion of number 1 or number 2 fuel oil exceeding a sulfur content of 0.5 percent by weight.

(2) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere in an amount greater than 2.5 pounds of sulfur dioxide, replicated maximum three-hour average, per million Btu of heat input from a liquid fuel-burning unit.

(3) Notwithstanding this paragraph, a fossil fuel-fired steam generator to which 23.1(2) "a," 23.1(2) "z" or 23.1(2) "ccc" applies shall comply with 23.1(2) "a," 23.1(2) "z" or 23.1(2) "ccc."

c. Sulfur dioxide from sulfuric acid manufacture. After January 1, 1975, no person shall allow, cause or permit the emission of sulfur dioxide from an existing sulfuric acid manufacturing plant in excess of 30 pounds of sulfur dioxide, maximum three-hour average, per ton of product calculated as 100 percent sulfuric acid.

d. Acid mist from sulfuric acid manufacture. After January 1, 1974, no person shall allow, cause or permit the emission of acid mist calculated as sulfuric acid from an existing sulfuric acid manufacturing plant in excess of 0.5 pounds, maximum three-hour average, per ton of product calculated as 100 percent sulfuric acid.

e. Other processes capable of emitting sulfur dioxide. After January 1, 1974, no person shall allow, cause or permit the emission of sulfur dioxide from any process, other than sulfuric acid manufacture, in excess of 500 parts per million, based on volume. This paragraph shall not apply to devices which have been installed for air pollution abatement purposes where it is demonstrated by the owner of the source that the ambient air quality standards are not being exceeded.

This rule is intended to implement Iowa Code section 455B.133.

567—23.4(455B) Specific processes.

23.4(1) General. The provisions of this rule shall not apply to those facilities for which performance standards are specified in 23.1(2). The emission standards specified in this rule shall apply and those specified in 23.3(2) “a” and 23.3(2) “b” shall not apply to each process of the types listed in the following subrules, except as provided below.

EXCEPTION: Whenever the director determines that a process complying with the emission standard prescribed in this section is causing or will cause air pollution in a specific area of the state, the specific emission standard may be suspended and compliance with the provisions of 23.3(455B) may be required in such instance.

23.4(2) Asphalt batching plants. No person shall cause, allow or permit the operation of an asphalt batching plant in a manner such that the particulate matter discharged to the atmosphere exceeds 0.15 grain per standard cubic foot of exhaust gas.

23.4(3) Cement kilns. Cement kilns shall be equipped with air pollution control devices to reduce the particulate matter in the gas discharged to the atmosphere to no more than 0.3 percent of the particulate matter entering the air pollution control device. Regardless of the degree of efficiency of the air pollution control device, particulate matter discharged from such kilns shall not exceed 0.1 grain per standard cubic foot of exhaust gas.

23.4(4) Cupolas for metallurgical melting. The emissions of particulate matter from all new foundry cupolas, and from all existing foundry cupolas with a process weight rate in excess of 20,000 pounds per hour, shall not exceed the amount specified in paragraph 23.3(2) “a,” except as provided in 567—Chapter 24.

The emissions of particulate matter from all existing foundry cupolas with a process weight rate less than or equal to 20,000 pounds per hour shall not exceed the amount determined from Table II of these rules, except as provided in 567—Chapter 24.

TABLE II
ALLOWABLE EMISSIONS FROM
EXISTING SMALL FOUNDRY CUPOLAS

Process weight rate (lb/hr)	Allowable emission (lb/hr)
1,000	3.05
2,000	4.70
3,000	6.35
4,000	8.00
5,000	9.58
6,000	11.30
7,000	12.90
8,000	14.30

Process weight rate (lb/hr)	Allowable emission (lb/hr)
9,000	15.50
10,000	16.65
12,000	18.70
16,000	21.60
18,000	23.40
20,000	25.10

23.4(5) *Electric furnaces for metallurgical melting.* The emissions of particulate matter to the atmosphere from electric furnaces used for metallurgical melting shall not exceed 0.1 grain per standard cubic foot of exhaust gas.

23.4(6) *Sand handling and surface finishing operations in metal processing.* This subrule shall apply to any new foundry or metal processing operation not properly termed a combustion, melting, baking or pouring operation. For purposes of this subrule, a new process is any process which has not started operation, or the construction of which has not been commenced, or the components of which have not been ordered or contracts for the construction of which have not been let on August 1, 1977. No person shall allow, cause or permit the operation of any equipment designed for sand shakeout, mulling, molding, cleaning, preparation, reclamation or rejuvenation or any equipment for abrasive cleaning, shot blasting, grinding, cutting, sawing or buffing in such a manner that particulate matter discharged from any stack exceeds 0.05 grains per dry standard cubic foot of exhaust gas, regardless of the types and number of operations that discharge from the stack.

23.4(7) *Grain handling and processing plants.* The owner or operator of equipment at a permanent installation for the handling or processing of grain, grain products and grain by-products shall not cause, allow or permit the particulate matter discharged to the atmosphere to exceed 0.1 grain per dry standard cubic foot of exhaust gas, except as follows:

a. The particulate matter discharged to the atmosphere from a grain bin vent at a country grain elevator, as “country grain elevator” is defined in 567—subrule 22.10(1), shall not exceed 1.0 grain per dry standard cubic foot of exhaust gas.

b. The particulate matter discharged to the atmosphere from a grain bin vent that was constructed, modified or reconstructed before March 31, 2008, at a country grain terminal elevator, as “country grain terminal elevator” is defined in 567—subrule 22.10(1), or at a grain terminal elevator, as “grain terminal elevator” is defined in 567—subrule 22.10(1), shall not exceed 1.0 grain per dry standard cubic foot of exhaust gas.

c. The particulate matter discharged to the atmosphere from a grain bin vent that is constructed or reconstructed on or after March 31, 2008, at a country grain terminal elevator, as “country grain terminal elevator” is defined in 567—subrule 22.10(1), or at a grain terminal elevator, as “grain terminal elevator” is defined in 567—subrule 22.10(1), shall not exceed 0.1 grain per dry standard cubic foot of exhaust gas.

23.4(8) *Lime kilns.* No person shall cause, allow or permit the operation of a kiln for the processing of limestone such that the particulate matter in the gas discharged to the atmosphere exceeds 0.1 grain per standard cubic foot of exhaust gas.

23.4(9) *Meat smokehouses.* No person shall cause, allow or permit the operation of a meat smokehouse or a group of meat smokehouses, which consume more than ten pounds of wood, sawdust or other material per hour such that the particulate matter discharged to the atmosphere exceeds 0.2 grain per standard cubic foot of exhaust gas.

23.4(10) *Phosphate processing plants.*

a. Phosphoric acid manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of phosphoric acid that was in existence on October 22, 1974, in a

manner that produces more than 0.04 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

b. Diammonium phosphate manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of diammonium phosphate that was in existence on October 22, 1974, in a manner that produces more than 0.15 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

c. Nitrophosphate manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of nitrophosphate in a manner that produces more than 0.06 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

d. No person shall allow, cause or permit the operation of equipment for the processing of phosphate ore, rock or other phosphatic material (other than equipment used for the manufacture of phosphoric acid, diammonium phosphate or nitrophosphate) in a manner that the unit emissions of fluoride exceed 0.4 pound of fluoride per ton of phosphorous pentoxide or its equivalent input.

e. Notwithstanding “*a*” through “*d*,” no person shall allow, cause or permit the operation of equipment for the processing of phosphorous ore, rock or other phosphatic material including, but not limited to, phosphoric acid, in a manner that emissions of fluorides exceed 100 pounds per day.

f. “Fluoride” means elemental fluorine and all fluoride compounds as measured by reference methods specified in Appendix A to 40 CFR Part 60 as amended through March 12, 1996.

g. Calculation. The allowable total emission of fluoride shall be calculated by multiplying the unit emission specified above by the expressed design production capacity of the process equipment.

23.4(11) *Portland cement concrete batching plants.* No person shall cause, allow or permit the operation of a Portland cement concrete batching plant such that the particulate matter discharged to the atmosphere exceeds 0.1 grain per standard cubic foot of exhaust gas.

23.4(12) *Incinerators.* A person shall not cause, allow or permit the operation of an incinerator unless provided with appropriate control of emissions of particulate matter and visible air contaminants.

a. Particulate matter. A person shall not cause, allow or permit the operation of an incinerator with a rated refuse burning capacity of 1000 or more pounds per hour in a manner such that the particulate matter discharged to the atmosphere exceeds 0.2 grain per standard cubic foot of exhaust gas adjusted to 12 percent carbon dioxide.

A person shall not cause, allow or permit the operation of an incinerator with a rated refuse burning capacity of less than 1000 pounds per hour in a manner such that the particulate matter discharged to the atmosphere exceeds 0.35 grain per standard cubic foot of exhaust gas adjusted to 12 percent carbon dioxide.

b. Visible emissions. A person shall not allow, cause or permit the operation of an incinerator in a manner such that it produces visible air contaminants in excess of 40 percent opacity; except that visible air contaminants in excess of 40 percent opacity but less than or equal to 60 percent opacity may be emitted for periods aggregating not more than 3 minutes in any 60-minute period during an operation breakdown or during the cleaning of air pollution control equipment.

23.4(13) *Painting and surface-coating operations.* No person shall allow, cause or permit painting and surface-coating operations in a manner such that particulate matter in the gas discharge exceeds 0.01 grain per standard cubic foot of exhaust gas.

This rule is intended to implement Iowa Code section 455B.133.

567—23.5(455B) Anaerobic lagoons.

23.5(1) Applications for construction permits for animal feeding operations using anaerobic lagoons shall meet the requirements of rules 567—65.9(455B) and 65.15(455B) to 65.17(455B).

23.5(2) Criteria for approval of industrial anaerobic lagoons.

a. Lagoons designed to treat 100,000 gpd or less.

(1) The sulfate content of the water supply shall not exceed 250 mg/l. However, this paragraph does not apply to an expansion of an industrial anaerobic lagoon facility which was constructed prior to February 22, 1979.

(2) The design loading rate for the total lagoon volume shall not be less than 10 pounds nor more than 20 pounds of biochemical oxygen demand (five day) per thousand cubic feet per day.

b. Lagoons designed to treat more than 100,000 gpd.

(1) The sulfate content of the water supply shall not exceed 100 mg/l. However, this paragraph does not apply to an expansion of an industrial anaerobic lagoon facility which was constructed prior to February 22, 1979.

(2) The design loading rate for the total lagoon volume shall not be less than 10 pounds nor more than 20 pounds of biochemical oxygen demand (five day) per thousand cubic feet per day.

This rule is intended to implement Iowa Code section 455B.133.

567—23.6(455B) Alternative emission limits (the “bubble concept”). Emission limits for individual emission points included in 23.3(455B) (except 23.3(2)“d,”23.3(2)“b”(3), and 23.3(3)“a”(3)) and 23.4(455B) (except 23.4(12)“b” and 23.4(6)) may be replaced by alternative emission limits. The alternative emission limits must be consistent with 567—22.7(455B) and 567—subrule 25.1(12). Under this rule, less stringent control limits where costs of emission control are high may be allowed in exchange for more stringent control limits where costs of control are less expensive.

Rules 23.3(455B) to 23.6(455B) are intended to implement Iowa Code section 455B.133.

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 [Editorial change: IAC Supplement 4/20/11]

[◇] Two or more ARCs

¹ Objection, see filed rule [DEQ, 4.2(4)] published IAC Supp. 1/22/77, 3/9/77.

² Effective date of 23.2(4) delayed 70 days by the Administrative Rules Review Committee on 9/14/83.

- ³ 11/24/10 effective date of 23.1(4), introductory paragraph, and 23.1(4)“*ev*” and “*fa*” to “*fd*” delayed 70 days by the Administrative Rules Review Committee at its meeting held November 9, 2010.
- ⁴ Amendment to 23.1(4), introductory paragraph, (ARC 9154B, Item 4) rescinded by Executive Order Number 72 on 4/4/11. Amendment removed and prior language restored IAC Supplement 4/20/11.

CHAPTER 124
DISCIPLINE FOR HEARING AID DISPENSERS
[Prior to 5/29/02, see 645—120.11(272C)]

645—124.1(154A,272C) Definitions.

“*Board*” means the board of hearing aid dispensers.

“*Discipline*” means any sanction the board may impose upon licensees.

“*Licensee*” means a person licensed to practice as a hearing aid dispenser in Iowa.

645—124.2(154A,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in rule 645—124.3(154A,272C) when the board determines that the licensee is guilty of any of the following acts or offenses:

124.2(1) Failure to comply with the current Code of Ethics of the International Hearing Society. The board hereby adopts by reference the current Code of Ethics of the International Hearing Society, available at <http://www.ihinfo.org>.

124.2(2) Fraud in procuring a license. Fraud in procuring a license includes, but is not limited to, the following:

- a. An intentional perversion of the truth in making application for a license to practice in this state;
- b. False representations of a 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
- c. Attempting to file or filing with the board or the department of public health any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a license in this state.

124.2(3) Professional incompetence. Professional incompetence includes, but is not limited to:

- a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice;
- b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other hearing aid dispensers in the state of Iowa acting in the same or similar circumstances;
- c. A failure to exercise the degree of care which is ordinarily exercised by the average hearing aid dispenser acting in the same or similar circumstances;
- d. Failure to conform to the minimal standard of acceptable and prevailing practice of licensed hearing aid dispensers in this state.

124.2(4) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of hearing aid dispensing or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

124.2(5) Advertising that hearing testing or hearing screening is for the purpose of detection or diagnosis of medical problems or medical screening for referral to a physician.

124.2(6) Failure to place all of the following in an advertisement relating to hearing aids:

- a. Hearing aid dispenser’s name.
- b. Hearing aid dispenser’s office address.
- c. Hearing aid dispenser’s telephone number.
- d. The qualifying words in the same size type as the title of the business: “for the purpose of fitting, selection, adaption, and sale of hearing aids.” However, the qualifying words are not required if the advertisement includes the words “hearing test,” “hearing evaluation,” “free hearing test,” “free hearing evaluation,” “hearing measurement,” or “free hearing measurement,” and the title of the business which is advertising appears in the advertisement and includes the words “hearing aid.”

124.2(7) Practice outside the scope of the profession.

124.2(8) The use of untruthful or improbable statements in advertisements. The use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public which is false, deceptive, misleading or promoted through fraud or misrepresentation.

124.2(9) Except in cases of selling replacement hearing aids of the same make or model within one year of the original sale, a hearing aid shall not be sold without adequate diagnostic testing and evaluation using established procedures to assess hearing needs as defined in 645—Chapter 123. Instruments shall be calibrated to current standards at least annually or more often if necessary. The distributor shall keep with the instruments a certificate indicating the date of calibration.

124.2(10) Habitual intoxication or addiction to the use of drugs.

a. The inability of a licensee to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.

b. The excessive use of drugs which may impair a licensee's ability to practice with reasonable skill or safety.

124.2(11) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

124.2(12) Falsification of client records.

124.2(13) Acceptance of any fee by fraud or misrepresentation.

124.2(14) Misappropriation of funds.

124.2(15) Negligence by the licensee in the practice of the profession. Negligence by the licensee in the practice of the profession includes a failure to exercise due care, including improper delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice or conditions which impair the ability to safely and skillfully practice the profession.

124.2(16) Conviction of a crime related to the profession or occupation of the licensee or the conviction of any crime that would affect the licensee's ability to practice as a hearing aid dispenser. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

124.2(17) Violation of a regulation, rule, or law of this state, another state, or the United States, which relates to the practice of hearing aid dispensing.

124.2(18) Revocation, suspension, or other disciplinary action taken by a licensing authority of this state, another state, territory or country; or failure of the licensee to report such action 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.

124.2(19) Failure of a licensee or an applicant for licensure in this state to report any voluntary agreements restricting the individual's practice as a hearing aid dispenser in another state, district, territory or country.

124.2(20) Failure to notify the board of a criminal conviction within 30 days of the action, regardless of the jurisdiction where it occurred.

124.2(21) Failure to notify the board within 30 days after occurrence of any judgment or settlement of a malpractice claim or action.

124.2(22) Engaging in any conduct that subverts or attempts to subvert a board investigation.

124.2(23) Failure to comply with a subpoena issued by the board or failure to cooperate with an investigation of the board.

124.2(24) Failure to respond within 30 days of receipt of communication from the board which was sent by registered or certified mail.

124.2(25) Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order.

124.2(26) Failure to pay costs assessed in any disciplinary action.

124.2(27) Submission of a false report of continuing education or failure to submit the biennial report of continuing education.

124.2(28) Failure to report another licensee to the board for any violations listed in these rules, pursuant to Iowa Code section 272C.9.

124.2(29) Knowingly aiding, assisting, or advising a person to unlawfully practice as a hearing aid dispenser.

124.2(30) Failure to report a change of name or address within 30 days after the occurrence.

124.2(31) Representing oneself as a licensed hearing aid dispenser when one's license has been suspended or revoked, or when one's license is on inactive status.

124.2(32) Permitting another person to use the licensee's license for any purpose.

124.2(33) Permitting an unlicensed employee or person under the licensee's control to perform activities that require a license.

124.2(34) Unethical conduct. In accordance with Iowa Code section 147.55(3), behavior (i.e., acts, knowledge, and practices) which constitutes unethical conduct may include, but is not limited to, the following:

- a. Verbally or physically abusing a patient, client, or coworker.
- b. Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient, client or coworker.
- c. Betrayal of a professional confidence.
- d. Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.
- e. Being adjudged mentally incompetent by a court of competent jurisdiction.

124.2(35) Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

124.2(36) Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

[ARC 9424B, IAB 3/9/11, effective 4/13/11 (See Delay note at end of chapter)]

645—124.3(154A,272C) Method of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revocation of license.
2. Suspension of license until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period the licensee's engaging in specified procedures, methods, or acts.
4. Probation.
5. Require additional education or training.
6. Require a reexamination.
7. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
8. Impose civil penalties not to exceed \$1000.
9. Issue a citation and warning.
10. Such other sanctions allowed by law as may be appropriate.

645—124.4(272C) Discretion of board. The following factors may be considered by the board in determining the nature and severity of the disciplinary sanction to be imposed:

1. The relative serious nature of the violation as it relates to ensuring a high standard of professional care for the citizens of this state;
2. The facts of the particular violation;
3. Any extenuating facts or other countervailing considerations;
4. The number of prior violations or complaints;
5. The seriousness of prior violations or complaints;
6. Whether remedial action has been taken; and
7. Such other factors as may reflect upon the competency, ethical standards, and professional conduct of the licensee.

645—124.5(154A) Order for mental, physical, or clinical competency examination or alcohol or drug screening. Rescinded IAB 1/14/09, effective 2/18/09.

These rules are intended to implement Iowa Code chapters 147, 154A and 272C.

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[Editorial change: IAC Supplement 4/20/11]

¹ April 13, 2011, effective date of 124.2(6) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

CHAPTER 71
ASSESSMENT PRACTICES AND EQUALIZATION
[Prior to 12/17/86, Revenue Department[730]]

701—71.1(405,427A,428,441,499B) Classification of real estate.

71.1(1) *Responsibility of assessors.* All real estate subject to assessment by city and county assessors shall be classified as provided in this rule. It shall be the responsibility of city and county assessors to determine the proper classification of real estate. There can be only one classification per property. An assessor shall not assign one classification to the land and a different classification to the building or separate classifications to the land or separate classifications to the building (dual classification). A building or structure on leased land is considered a separate property and may be classified differently than the land upon which it is located. The determination shall be based upon the best judgment of the assessor following the guidelines set forth in this rule and the status of the real estate as of January 1 of the year in which the assessment is made. The assessor shall classify property according to its present use and not according to its highest and best use. See subrule 71.1(8) for an exception to the general rule that property is to be classified according to its use. The classification shall be utilized on the abstract of assessment submitted to the department of revenue pursuant to Iowa Code section 441.45. See rule 701—71.8(428,441).

71.1(2) *Responsibility of boards of review, county auditors, and county treasurers.* Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall classify property as provided in this rule and adhere to the requirements of this rule.

71.1(3) *Agricultural real estate.* Agricultural real estate shall include all tracts of land and the improvements and structures located on them which are in good faith used primarily for agricultural purposes except buildings which are primarily used or intended for human habitation as defined in subrule 71.1(4). Land and the nonresidential improvements and structures located on it shall be considered to be used primarily for agricultural purposes if its principal use is devoted to the raising and harvesting of crops or forest or fruit trees, the rearing, feeding, and management of livestock, or horticulture, all for intended profit.

Vineyards and any buildings located on a vineyard and used in connection with the vineyard shall be classified as agricultural real estate if the primary use of the land and buildings is an activity related to the production or sale of wine.

Agricultural real estate shall also include woodland, wasteland, and pastureland, but only if that land is held or operated in conjunction with agricultural real estate as defined in this subrule.

71.1(4) *Residential real estate.* Residential real estate shall include all lands and buildings which are primarily used or intended for human habitation, including those buildings located on agricultural land. Buildings used primarily or intended for human habitation shall include the dwelling as well as structures and improvements used primarily as a part of, or in conjunction with, the dwelling. This includes but is not limited to garages, whether attached or detached, tennis courts, swimming pools, guest cottages, and storage sheds for household goods. Residential real estate located on agricultural land shall include only buildings as defined in this subrule. Buildings for human habitation that are used as commercial ventures, including but not limited to hotels, motels, rest homes, and structures containing three or more separate living quarters shall not be considered residential real estate. However, regardless of the number of separate living quarters, multiple housing cooperatives organized under Iowa Code chapter 499A and land and buildings owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be considered residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use for human habitation shall be classified as residential real estate regardless of who occupies the apartment. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

71.1(5) Commercial real estate. Commercial real estate shall include all lands and improvements and structures located thereon which are primarily used or intended as a place of business where goods, wares, services, or merchandise is stored or offered for sale at wholesale or retail. Commercial realty shall also include hotels, motels, rest homes, structures consisting of three or more separate living quarters and any other buildings for human habitation that are used as a commercial venture. Commercial real estate shall also include data processing equipment as defined in Iowa Code section 427A.1(1)“j,” except data processing equipment used in the manufacturing process. However, regardless of the number of separate living quarters or any commercial use of the property, single- and two-family dwellings, multiple housing cooperatives organized under Iowa Code chapter 499A, and land and buildings used primarily for human habitation and owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be classified as residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use as a commercial venture, other than leased for human habitation, shall be classified as commercial real estate. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

71.1(6) Industrial real estate.

a. Land and buildings.

(1) Industrial real estate includes land, buildings, structures, and improvements used primarily as a manufacturing establishment. A manufacturing establishment is a business entity in which the primary activity consists of adding to the value of personal property by any process of manufacturing, refining, purifying, the packing of meats, or the combination of different materials with the intent of selling the product for gain or profit. Industrial real estate includes land and buildings used for the storage of raw materials or finished products and which are an integral part of the manufacturing establishment, and also includes office space used as part of a manufacturing establishment.

(2) Whether property is used primarily as a manufacturing establishment and, therefore, assessed as industrial real estate depends upon the extent to which the property is used for the activities enumerated in subparagraph 71.1(6)“a”(1). Property in which the performance of these activities is only incidental to the property’s primary use for another purpose is not a manufacturing establishment. For example, a grocery store in which bakery goods are prepared would be assessed as commercial real estate since the primary use of the grocery store premises is for the sale of goods not manufactured by the grocery and the industrial activity, i.e., baking, is only incidental to the store premises’ primary use. However, property which is used primarily as a bakery would be assessed as industrial real estate even if baked goods are sold at retail on the premises since the bakery premises’ primary use would be for an industrial activity to which the retail sale of baked goods is merely incidental. See *Lichty v. Board of Review of Waterloo*, 230 Iowa 750, 298 N.W. 654 (1941).

Similarly, a facility which has as its primary use the mixing and blending of products to manufacture feed would be assessed as industrial real estate even though a portion of the facility is used solely for the storage of grain, if the use for storage is merely incidental to the property’s primary use as a manufacturing establishment. Conversely, a facility used primarily for the storage of grain would be assessed as commercial real estate even though a part of the facility is used to manufacture feed. In the latter situation, the industrial use of the property — the manufacture of feed — is merely incidental to the property’s primary use for commercial purposes — the storage of grain.

(3) Property used primarily for the extraction of rock or mineral substances from the earth is not a manufacturing establishment if the only processing performed on the substance is to change its size by crushing or pulverizing. See *River Products Company v. Board of Review of Washington County*, 332 N.W.2d 116 (Iowa Ct. App. 1982).

b. Machinery.

(1) Machinery includes equipment and devices, both automated and nonautomated, which is used in manufacturing as defined in Iowa Code section 428.20. See *Deere Manufacturing Co. v. Beiner*, 247 Iowa 1264, 78 N.W.2d 527 (1956).

(2) Machinery owned or used by a manufacturer but not used within the manufacturing establishment is not assessed as industrial real estate. For example, “X” operates a factory which manufactures building materials for sale. In addition, “X” uses some of these building materials in construction contracts. The machinery which “X” would primarily use at the construction site would not be used in a manufacturing establishment and, therefore, would not be assessed as industrial real estate.

(3) Machinery used in manufacturing but not used in or by a manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963).

(4) Where the primary function of a manufacturing establishment is to manufacture personal property that is consumed by the manufacturer rather than sold, the machinery used in the manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963).

71.1(7) Point-of-sale equipment. As used in Iowa Code section 427A.1(1)“j,” the term “point-of-sale equipment” means input, output, and processing equipment used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and which is located at the counter, desk, or other specific point at which the transaction occurs. As used in this subrule, the term “sale” means the sale or rental of goods or services and includes both retail and wholesale transactions. Point-of-sale equipment does not include equipment used primarily for depositing or withdrawing funds from financial institution accounts.

71.1(8) Housing development property. A county board of supervisors may adopt an ordinance providing that property acquired and subdivided for development of housing be classified the same as it was prior to its acquisition until the property is sold or, depending on a county’s population, for a specified number of years from the date of subdivision, whichever is shorter. The applicable time period is five years in counties with a population of less than 20,000 and three years in counties with a population of 20,000 or more. The property is to be classified as residential or commercial, whichever is applicable, in the assessment year following the year in which it is sold or the applicable time period has expired. For purposes of this subrule, “subdivided” means to divide a tract of land into three or more lots.

This rule is intended to implement Iowa Code sections 405.1, 427A.1, 428.4 and 441.22 and chapter 499B and Iowa Code Supplement section 441.21 as amended by 2002 Iowa Acts, House File 2584. [ARC 8559B, IAB 3/10/10, effective 4/14/10]

701—71.2(421,428,441) Assessment and valuation of real estate.

71.2(1) Responsibility of assessor. The valuation of real estate as established by city and county assessors shall be the actual value of the real estate as of January 1 of the year in which the assessment is made. New parcels of real estate created by the division of existing parcels of real estate shall be assessed separately as of January 1 of the year following the division of the existing parcel of real estate.

71.2(2) Responsibility of other assessing officials. Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall follow the provisions of subrule 71.2(1) and rules 71.3(421,428,441) to 71.7(421,427A,428,441).

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

701—71.3(421,428,441) Valuation of agricultural real estate. Agricultural real estate shall be assessed at its actual value as defined in Iowa Code section 441.21 by giving exclusive consideration to its productivity and net earning capacity. In determining the actual value of agricultural real estate, city and county assessors shall use the Iowa Real Property Appraisal Manual and any other guidelines issued by the department of revenue pursuant to Iowa Code section 421.17(18).

71.3(1) Productivity. In determining the productivity and net earning capacity of agricultural real estate, the assessor shall also use available data from Iowa State University, the United States Department of Agriculture (USDA) National Agricultural Statistics Service, the USDA Farm Service Agency, the Iowa department of revenue, or other reliable sources. The assessor shall also consider the results of a modern soil survey, if completed. The assessor shall determine the actual valuation of agricultural real

estate within the assessing jurisdiction and spread such valuation throughout the jurisdiction so that each parcel of real estate is assessed at its actual value as defined in Iowa Code section 441.21.

71.3(2) Agricultural factor. In order to determine a productivity value for agricultural buildings and structures, assessors must make an agricultural adjustment to the market value of these buildings and structures by developing an “agricultural factor” for the assessors’ jurisdictions. The agricultural factor for each jurisdiction is the product of the ratio of the productivity and net earning capacity value per acre as determined under subrule 71.12(1) over the market value of agricultural land within the assessing jurisdiction. The resulting ratio is then applied to the actual value of the agricultural buildings and structures as determined under the Iowa Real Property Appraisal Manual prepared by the department. The agricultural factor must be applied uniformly to all agricultural buildings and structures in the assessing jurisdiction. As an example, if a building’s actual value is \$500,000 and the agricultural factor is 30 percent, the productivity value of that building is \$150,000. See *H & R Partnership v. Davis County Board of Review*, 654 N.W.2d 521 (Iowa 2002). The 2007, 2008, and 2009 average of the market value of land will be used in determining the agricultural factor for assessment year 2011. A five-year market value average of land for years used to determine the productivity formula will be used to determine the agricultural factor for assessment year 2013 and subsequent assessment years.

71.3(3) Classification. Land classified as agricultural real estate includes the land beneath any dwelling and appurtenant structures located on that land and shall be valued by the assessor pursuant to rule 701—71.3(421,428,441). An assessor shall not value a part of the land as agricultural real estate and a part of the land as if it is residential real estate.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.
[ARC 8542B, IAB 2/24/10, effective 3/31/10; ARC 9478B, IAB 4/20/11, effective 5/25/11]

701—71.4(421,428,441) Valuation of residential real estate. Residential real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of residential real estate, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

701—71.5(421,428,441) Valuation of commercial real estate. Commercial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21. In determining the actual value of commercial real estate, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

71.5(1) Property of long distance telephone companies. The director of revenue shall assess the property of long distance telephone companies as defined in Iowa Code section 476.1D(10) which property is first assessed for taxation on or after January 1, 1996, in the same manner as commercial real estate.

71.5(2) Low-income housing subject to Section 42 of the Internal Revenue Code.

a. Productive and earning capacity. In assessing property that is rented or leased to low-income individuals and families as authorized by Section 42 of the Internal Revenue Code which limits the amount that the individual or family pays for the rental or lease of units in the property, the assessor shall use the productive and earning capacity from the actual rents received as a method of appraisal and shall take into account the extent to which that use and limitation reduces the market value of the property.

b. Direct capitalization method. The income approach to valuation shall be applied using the direct capitalization method. The assessor may use the discounted cash flow method as a test of the reasonableness of the results produced by the direct capitalization method. The direct capitalization method of the income approach involves dividing the Net Operating Income (NOI) on a cash basis by an overall capitalization rate to derive an indication of the value of the property for the assessment year.

In applying the direct capitalization method, the assessor shall develop a normalized measure of annual NOI based on the productive and earning capacity of the development utilizing (1) the actual rent schedule applicable for each of the available units as of January 1 of the year of assessment indicating the actual rent to be paid by the resident plus any Section 8 rental assistance or other direct cash rental subsidy provided to the resident by federal, state or local rent subsidy programs as limited pursuant to Section 42 of the Internal Revenue Code, (2) a normal vacancy/collection allowance, (3) the prior year's actual and current year's projected annual operating expenses associated with the property, excluding noncash items such as depreciation and amortization, but including property taxes and those actual costs expected to be incurred and paid as required by Internal Revenue Code Section 42 regulations, provisions, and restrictions as applicable to the assessment year, and (4) an appropriate provision for replacement reserves.

If no separate line item is included for reserves for replacement in the historic income and expense data, then the maintenance and repair categories of the historic expense data must be itemized. For properties that have attained a normalized operating history, the NOI results of the prior three years (as represented in the statements variously named as the Income and Loss Statement, the Profit and Loss Statement, the Income Statement, the Actual to Budget Comparison Statement, Balance Sheet, or some name variation of these) may be used to provide the basis for determining the normalized NOI used for purposes of applying the direct capitalization method for the year of assessment, provided an appropriate replacement reserve is included in the NOI determination and provided any additional costs required as a result of Section 42 regulation or compliance changes for the assessment year are included as an operating expense in the NOI determination. In addition, the assessor may utilize the current year operating budget to develop a measure of NOI for the assessment year. The assessor, in developing the measure of annual NOI on a cash basis, shall not consider as income any potential rental income differential that could otherwise be received from the property if the rents were not limited pursuant to Section 42 of the Internal Revenue Code, any tax credit equity, any tax credit value, or other subsidized financing.

c. Filing of reports. It shall be the responsibility of the property owner to file income and expense data with the local assessor by March 1 of each year. The assessor may require the filing of additional information if deemed necessary.

d. Capitalization rate. The overall capitalization rate to be used in applying the direct capitalization method for a Section 42 property is developed through the band-of-investment technique. The capitalization rate will be calculated annually by the Iowa department of revenue and distributed to all Iowa assessors by March 1. The capitalization rate is a composite rate weighted by the proportions of total property investment represented by debt and equity. The capital structure weights equity at 80 percent and debt at 20 percent unless actual market capital structure can be verified to the assessor. The yield, or market rate of return, for equity is calculated using the capital asset pricing model (CAPM). The yield for debt is equivalent to the average yield on 25-year Treasury bonds referred to as the Treasury long-term average rate. An example of the band-of-investment technique to be utilized is as follows:

	% to Total	Yield	Composite
Equity	80%	11.05%	8.84%
Debt	20%	5.94%	1.19%
	100%		10.03%

e. Capital asset pricing model. The capital asset pricing model (CAPM) is utilized to develop the equity rate. The formula is:

$$Re = B(Rm - Rf) + Rf$$

Where:

Re	=	return on equity
B	=	beta
Rm	=	return on the market
Rf	=	risk-free rate of return
Rm - Rf	=	market-risk premium

The beta is assumed to be 1 which indicates the risk level to be consistent with the market as a whole. The risk-free rate is calculated by finding the average of the three-month and six-month Treasury bill. The return on the market is calculated by taking the average of the return on the market for the Merrill Lynch Universe and Standard and Poor's 500 or by reference to other published secondary sources.

f. Properties under construction. For Section 42 properties under construction, the assessor may value the property by applying the percentage of completion to the replacement cost new (RCN) as calculated from the Iowa Real Property Appraisal Manual and adding the fair market value of the land. Alternatively, projected income and expense data may be utilized if available.

g. Negative or minimal NOI. If the Section 42 property shows a negative or minimal net operating income (NOI), the indicator of value as set forth in these rules shall not be utilized.

h. Eligibility withdrawn. The property owner shall notify the assessor when property is withdrawn from Section 42 eligibility under the Internal Revenue Code. The notification must be provided by March 1 of the assessment year or the owner is subject to a penalty of \$500.

This rule is intended to implement Iowa Code sections 421.17, 428.4, 441.21 as amended by 2004 Iowa Acts, Senate File 2296, and 476.1D(10).

701—71.6(421,428,441) Valuation of industrial land and buildings. Industrial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of industrial land and buildings, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code subsection 421.17(18), and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

701—71.7(421,427A,428,441) Valuation of industrial machinery. Industrial machinery as referred to in Iowa Code section 427A.1(1) "e" shall include all machinery used in manufacturing establishments and shall be assessed as real estate even though such machinery might be assessed as personal property if not used in a manufacturing establishment.

In determining the actual value of industrial machinery assessed as real estate, the assessor shall give consideration to the "Industrial Machinery and Equipment Valuation Guide" issued by the department of revenue and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 427A.1, 428.4 and 441.21.

701—71.8(428,441) Abstract of assessment. Each city and county assessor shall submit annually to the director of revenue at the times specified in Iowa Code section 441.45 an abstract of assessment for the current year. The assessor shall use the form of abstract prescribed and furnished by the department of revenue, and shall enter on the abstract all information required by the department. However, the department may approve the use of a computer-prepared abstract if the data is essentially the same format as on the form prescribed by the department. The information entered on the abstract of assessment shall be reviewed and considered by the director of revenue in equalizing the valuations of classes of properties.

This rule is intended to implement Iowa Code sections 428.4 and 441.45.

701—71.9(428,441) Reconciliation report. The assessor's report of any revaluation required by Iowa Code section 428.4 shall be made on the reconciliation report prescribed and furnished by the department of revenue. The assessor shall enter on the report all information required by the department. The reconciliation report shall be a part of the abstract of assessment required by Iowa Code section 441.45 and shall be reviewed and considered by the director in equalizing valuations of classes of property.

This rule is intended to implement Iowa Code sections 428.4 and 441.45.

701—71.10(421) Assessment/sales ratio study.

71.10(1) Basic data. Basic data shall be that submitted to the department of revenue by county recorders and city and county assessors on forms prescribed and provided by the department, information furnished by parties to real estate transactions, and information obtained by field investigations made by the department of revenue.

71.10(2) Responsibility of recorders and assessors. County recorders and city and county assessors shall complete the prescribed forms as required by Iowa Code subsection 421.17(6) and rule 701—79.3(428A) in accordance with instructions issued by the department. Assessed values entered on the prescribed form shall be those established as of January 1 of the year in which the sale takes place.

71.10(3) Normal sales. All real estate transfers shall be considered by the department of revenue to be normal sales unless there exists definite information which would indicate the transfer was not an arms-length transaction or is of an excludable nature as provided in Iowa Code section 441.21.

This rule is intended to implement Iowa Code section 421.17.

701—71.11(441) Equalization of assessments by class of property. Commencing in 1977 and every two years thereafter, the director of revenue shall order the equalization of the levels of assessment of each class of property as provided in rule 71.12(441) by adding to or deducting from the valuation of each class of property, as reported to the department on the abstract of assessment and reconciliation report which is a part of the abstract, the percentage in each case as may be necessary to bring the level of assessment to its actual value as defined in Iowa Code section 441.21. Valuation adjustments shall be ordered if the director determines that the aggregate valuation of a class of property as reported on the abstract of assessment submitted by the assessor is at least 5 percent above or below the aggregate valuation for that class of property as determined by the director pursuant to rule 71.12(441). Equalization orders of the director shall be restricted to equalizing the aggregate valuations of entire classes of property among the several assessing jurisdictions. All classifications of real estate shall be applied uniformly throughout the state of Iowa.

Equalization percentage adjustments determined for residential realty located outside incorporated areas and not located on agricultural land shall apply to buildings located on agricultural land outside incorporated areas, which are primarily used or intended for human habitation, as defined in subrule 71.1(4).

Equalization percentage adjustments determined for residential realty located within incorporated cities and not located on agricultural land shall apply to buildings located on agricultural land within incorporated cities which are primarily used or intended for human habitation as defined in subrule 71.1(4).

This rule is intended to implement Iowa Code sections 441.21, 441.47, 441.48 and 441.49.

701—71.12(441) Determination of aggregate actual values.

71.12(1) Agricultural real estate.

a. Use of income capitalization study. The equalized valuation of agricultural realty shall be based upon its productivity and net earning capacity and shall be determined in accordance with the provisions of this subrule. Data used shall pertain to crops harvested during the five-year period ending with the calendar year in which assessments were last equalized. The equalized valuation of agricultural realty shall be determined for each county as follows:

(1) Computation of county acres. This information shall be obtained from the USDA National Agricultural Statistics Service.

1. Total acres in farms: Total acreage used for agricultural purposes.
2. Corn acres: Sum of corn acres harvested including silage, popcorn and acres planted for sorghum.
3. Oats and wheat acres: Sum of oats and wheat acres harvested.
4. Soybean acres: Soybean acres harvested.
5. Hay acres: All hay acres harvested.
6. Pasture acres: All pasture acres. Total pasture acres shall be determined by multiplying the total acres in farms reported by the USDA National Agricultural Statistics Service by the percentage which total pasture land as reported in the most recent U.S. Census of Agriculture bears to the total acreage in farmland also reported in the most recent U.S. Census of Agriculture. The amount of tillable and nontillable pasture acres shall be determined as follows:

1.	From the most recent U.S. Census of Agriculture obtain the following:		
	Cropland used only for pasture and grazing	_____	acres
	Woodland pasture	_____	acres
	Pasture land and rangeland (other than cropland and woodland pasture)	_____	acres
	TOTAL PASTURE LAND (total of above):	_____	acres
2.	Determine what percentage of the total pasture land is cropland used only for pasture:	_____	%
3.	Apply the percentage in "2" above to the 5-year average total acres of pasture as determined above to determine the pasture acres to be classified as tillable pasture. The remainder of the 5-year average shall be classified as nontillable pasture land.	_____	acres

7. Government programs: Determine the 5-year average acres participating in applicable government programs. Obtain data from the USDA Farm Service Agency, including but not limited to acreage devoted to the Payment-In-Kind (PIK), diverted and deficiency programs.

8. Other acres: The difference between the total acreage for land uses listed above and the total of all land in farms. Add the total of the corn, oats, soybeans, hay, tillable and nontillable pasture and diverted acres. Subtract this total from total acres in farms. The residual is classified as other acres.

(2) Computation of county yields. This information shall be obtained for each county from the USDA National Agricultural Statistics Service.

1. Corn yield (including silage): Number of bushels of corn harvested for grain per acre.
2. Oat yield (including wheat): Number of bushels of oats harvested per acre.
3. Soybean yield: Number of bushels per acre harvested.
4. Hay yield in tons: Number of tons per acre harvested.

(3) Computation of county gross income.

1. Corn: One-half of the 5-year average production multiplied by the 5-year average price received for corn.

2. Silage: One-half of the 5-year average number of acres devoted to the production of silage multiplied by the 5-year average production per acre for corn. The amount of production so determined shall be added to the 5-year average production for corn and included in the determination of the gross income for corn.

3. Soybeans: One-half of the 5-year average production multiplied by the 5-year average price received.

4. Oats: One-half of the 5-year average production of oats and wheat multiplied by the 5-year average price received for oats.

5. Price adjustment: For corn, soybeans, hay, and oats, the prices used shall be as obtained from the USDA National Agricultural Statistics Service and shall be adjusted to reflect any individual county price conditions prior to the 2007 crop year. For the 2007 crop year and later, the USDA National Agricultural Statistics Service district prices shall be used and shall be adjusted to reflect any individual county price conditions.

6. Government programs: Gross income shall be one-half of the 5-year average amount of cash payments or equivalent (such as PIK bushels) including but not limited to diverted, deficiency and PIK programs as reported by the USDA Farm Service Agency.

7. Hay: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to hay by the product obtained by multiplying one-fourth of the 5-year average hay yield by the 5-year average price received for all types of hay.

8. Tillable pasture: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to tillable pasture by the product obtained in "hay" above.

9. Nontillable pasture: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to nontillable pasture by one-half the product obtained in "hay" above.

10. Other acres: Income shall be the product of the number of other acres multiplied by 17 percent of the net income per acre for all other land uses.

(4) Computation of county production costs. The following data and procedures shall be used to determine specific county production costs.

1. Basic average landlord production costs. Landlord production costs for corn, soybeans, oats, diverted acres, hay, tillable pasture, nontillable pasture, fertilizer costs, and facilities' costs shall be obtained for each year from Iowa State University.

2. Production cost adjustment. The production costs for corn, soybeans, oats, and hay are adjusted for each county by multiplying the difference between the 5-year state average yield per acre and the 5-year county average yield per acre by the 5-year average facilities' costs. If a county's yield exceeds the state yield, production costs are increased by this amount. If a county's yield is less than the state yield, production costs are reduced by this amount.

3. Fertilizer cost adjustment. The adjustment for fertilizer costs is determined as follows: Multiply the difference between the 5-year state average corn yield per acre and the 5-year county average corn yield per acre obtained from the USDA National Agricultural Statistics Service by the fertilizer cost amount per bushel determined by dividing the statewide average cost of landlord's share of fertilizer cost per acre from Iowa State University by the statewide average corn yield per acre to produce the corn fertilizer cost per bushel adjustment. This amount is then multiplied by the 5-year county average corn acres determined in (2) above.

4. Expense adjustments. If a county's 5-year average corn yield is greater than the state 5-year average corn yield, this amount is allowed as an additional expense. If the county's average is less than the state average, this amount is an expense reduction.

5. Liability insurance cost adjustment. The 5-year average per acre cost of obtaining tort liability insurance shall be determined.

(5) Computation of county net income. From the total gross income, subtract the total expenses. Divide the resulting total by the total number of acres.

(6) Computation of dwelling adjustment factor. The amount determined in (5) above shall be reduced by 10.6 percent.

(7) Computation of county tax adjustment. Subtract the 5-year average per acre real estate taxes levied for land and structures including drainage and levee district taxes but excluding those levied against agricultural dwellings from the amount determined in (6) above. Taxes shall be the tax levied for collection during the 5-year period as reported by county auditors, and reduced by the amount of the agricultural land tax credit.

(8) Calculation of county valuation per acre. Divide the net income per acre ((7) above) for each county as determined above by the capitalization rate specified in Iowa Code section 441.21. The

quotient shall be the actual per acre equalized valuation of agricultural land and structures for the current equalization year.

b. Use of other relevant data. The director may also consider other relevant data, including field investigations conducted by representatives of the department of revenue, to determine the level of assessment of agricultural real estate.

c. Determination of value. The aggregate actual value of agricultural real estate in each county shall be determined by multiplying the equalized per acre value by the number of acres of agricultural real estate reported on the abstract of assessment for the current year, adjusted where necessary by the results of any field investigations conducted by the department of revenue and any other relevant data available.

71.12(2) Residential real estate outside and within incorporated cities.

a. Use of assessment/sales ratio study. Basic data shall be that set forth in rule 71.10(421) refined by eliminating any sales determined to be abnormal or by adjusting the sales to eliminate the effects of factors which resulted in the sales having been determined to be abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The director may also supplement the assessment/sales ratio study with appraisals made by department of revenue appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of residential real estate in each assessing jurisdiction. The director of revenue may consider sales and appraisal data for prior years if it is determined the use of the sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value.

Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals which would indicate abnormal or unusual conditions or reporting discrepancies which would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

b. Use of other relevant data. The director may also consider other relevant data, including field investigations conducted by representatives of the department of revenue to determine the level of assessment of residential real estate.

c. Equalization appraisal selection procedures for residential real estate. Residential properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the following manner:

(1) The department appraiser assigned to the jurisdiction shall determine a systematic random sequence of numbers equal to the number of appraisals required and document the following steps.

1. The department appraiser assigned to the jurisdiction shall compute the interval number by dividing the total number of improved properties in the classification to be sampled by the number of appraisals to be performed.

EXAMPLE: In this example, ten appraisals are needed with a total of 1,397 improved residential units. Dividing 1,397 by 10, 139.7 is arrived at, which is rounded down to 139. This is the interval number.

2. The selection of the first sequence number shall be accomplished by having an available disinterested person randomly select a number from one through the interval number.

EXAMPLE: In this example a number from 1 to 139 is to be selected. The person randomly selected number 20.

3. The department appraiser shall develop a systematic sequence of numbers equal to the number of appraisals required. Starting with the randomly selected number previously picked by the disinterested person, add the interval number to this number and to each resulting number until a systematic sequence of numbers is obtained.

EXAMPLE: In this example ten appraisals are needed, so a sequence of ten numbers must be developed. Starting with number 20 and adding the interval number of 139 to it, each resulting number provides the following systematic sequence: 20, 159, 298, 437, 576, 715, 854, 993, 1,132, 1,271.

(2) Number of improved properties.

County jurisdictions—Put the name of each city or township having improved units in the classification to be sampled into a hat. Draw each one out of the hat and record its name in the order of its draw. Likewise, record the respective number of improved units for each. Then consecutively number all the improved units and document the procedure.

EXAMPLE:

City or Township	Number of Improved Residential Units	Code Numbers
Franklin Twp.	57	1-57
Pleasant View	160	58-217
Jackson Twp.	56	218-273
Johnston	300	274-573
Polk Twp.	110	574-683
Washington Twp.	114	684-797
Maryville	306	798-1103
Camden Twp.	110	1104-1213
Salem	184	1214-1397
Total	1,397	

(3) Determine the location of the improved properties selected for appraisal and document the procedure.

EXAMPLE:

City or Township	Number of Improved Residential Units	Code Numbers	Sequence Number	Entry on Rolls
Franklin Twp.	57	1-57	20	20
Pleasant View	160	58-217	159	102
Jackson Twp.	56	218-273		
Johnston	300	274-573	298,437	25,164
Polk Twp.	110	574-683	576	3
Washington Twp.	114	684-797	715	32
Maryville	306	798-1103	854,993	57,196
Camden Twp.	110	1104-1213	1132	29
Salem	184	1214-1397	1271	58
Total	1,397			

1. The department appraiser shall locate the property to be appraised by finding the relationship between the sequence numbers and the code numbers and identify the property.

EXAMPLE: The first sequence number is 20. Since the improved residential properties in Franklin Township have been assigned code numbers 1 to 57, sequence number 20 is in that location.

To identify this property, examine the Franklin Township assessment roll book and stop at the twentieth improved residential entry.

Document the parcel number, owner’s name, and legal description of this property.

2. The department appraiser shall appraise the property selected unless it is ineligible because of any of the following restrictions:

Current year sale
 Partial assessment
 Prior equalization appraisal
 Tax-exempt
 Value established by court action
 Value is not more than \$10,000
 Building on leased land

3. The department appraiser shall determine a substitute property if the originally selected one is ineligible. In ascending order, select code numbers until an eligible property is found.

EXAMPLE: If code number 20 is ineligible, use code number 21 as a substitute. If code number 21 is ineligible, use code number 22, etc., until an eligible property is found.

If the procedure described in 71.12(2)“c”(3)“3” moves the substitute property to another city or township, select substitute code numbers in descending order until an eligible property is found.

If the procedure described in the previous paragraph moves the substitute property to a preceding city or township, go back to the procedure of 71.12(2)“c”(3)“3” even if it moves the substitute property to a subsequent city or township.

4. Select an alternate property for the originally selected property which also would be eligible. This is necessary because at the time of appraisal the property may be found to be ineligible due to one of the restrictions in 71.12(2)“c”(3)“2.” Alternate properties are selected by using the same procedure described in 71.12(2)“c”(3)“3.”

5. Follow procedures 71.12(2)“c”(3), items “1” to “4,” for each of the other originally selected sequence numbers.

71.12(3) Commercial real estate.

a. Use of assessment/sales ratio study. Basic data shall be that set forth in rule 71.10(421), refined by eliminating any sales determined to be abnormal or by adjusting same to eliminate the effects of factors which resulted in the sales having been determined to be abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The director may also supplement the assessment/sales ratio study with appraisals made by department of revenue appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of commercial real estate in each assessing jurisdiction. The director of revenue may consider sales and appraisal data for prior years if it is determined the use of sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value.

b. Use of other relevant data. The director may also consider other relevant data, including field investigations conducted by representatives of the department of revenue to determine the level of assessment of commercial real estate. The diverse nature of commercial real estate precludes the use of a countywide or citywide income capitalization study.

Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals which would indicate abnormal or unusual conditions or reporting discrepancies which would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

c. Equalization appraisal selection procedures for commercial real estate. Commercial properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the following manner:

(1) The department appraiser assigned to the jurisdiction shall determine a systematic random sequence of numbers equal to the number of appraisals required and document the following steps.

1. The department appraiser shall compute the interval number by dividing the total number of improved properties in the classification to be sampled by the number of appraisals to be performed.

EXAMPLE: In this example, ten appraisals are needed with a total of 397 improved commercial units. Dividing 397 by 10, 39.7 is arrived at, which is rounded down to 39. This is the interval number.

2. The selection of the first sequence number shall be accomplished by having an available disinterested person randomly select a number from one through the interval number.

EXAMPLE: In this example a number from 1 to 39 is to be selected. The person randomly selected number 2.

3. The department appraiser shall develop a systematic sequence of numbers equal to the number of appraisals required. Starting with the randomly selected number previously picked by the disinterested person, add the interval number to this number and to each resulting number until a systematic sequence of numbers is obtained.

EXAMPLE: In this example ten appraisals are needed, so a sequence of ten numbers must be developed. Starting with number 2 and adding the interval number of 39 to it, each resulting number provides the following systematic sequence: 2, 41, 80, 119, 158, 197, 236, 275, 314, 353.

(2) Number of improved properties.

1. City jurisdictions—Utilizing the assessment book or a computer printout which follows the same order as the assessment book, consecutively number all the improved units and document the procedure.

2. County jurisdictions—Put the name of each city or township having improved units in the classification to be sampled into a hat. Draw each one out of the hat and record its name in the order of its draw. Likewise, record the respective number of improved units for each. Then consecutively number all the improved units and document the procedure.

EXAMPLE:

City or Township	Number of Improved Commercial Units	Code Numbers
Franklin Twp.	4	1-4
Pleasant View	60	5-64
Jackson Twp.	9	65-73
Johnston	100	74-173
Polk Twp.	10	174-183
Washington Twp.	14	184-197
Maryville	106	198-303
Camden Twp.	10	304-313
Salem	84	314-397
Total	<u>397</u>	

(3) The department appraiser shall determine the location of the improved properties selected for appraisal and document the procedure.

EXAMPLE:

City or Township	Number of Improved Commercial Units	Code Numbers	Sequence Number	Entry on Rolls
Franklin Twp.	4	1-4	2	2
Pleasant View	60	5-64	41	37
Jackson Twp.	9	65-73		
Johnston	100	74-173	80,119,158	7,46,85
Polk Twp.	10	174-183		

<u>City or Township</u>	<u>Number of Improved Commercial Units</u>	<u>Code Numbers</u>	<u>Sequence Number</u>	<u>Entry on Rolls</u>
Washington Twp.	14	184-197	197	14
Maryville	106	198-303	236,275	39,78
Camden Twp.	10	304-313		
Salem	84	314-397	314,353	1,40
Total	<u>397</u>			

1. The department appraiser shall locate the property to be appraised by finding the relationship between the sequence numbers and the code numbers and identify the property.

EXAMPLE: The first sequence number is 2. Since the improved commercial properties in Franklin Township have been assigned code numbers 1 to 4, sequence number 2 is in that location.

To identify this property, examine the Franklin Township assessment roll book and stop at the second improved commercial entry.

The department appraiser shall document the parcel number, owner's name, and legal description of this property.

2. The department appraiser shall appraise the property selected unless it is ineligible because of any of the following restrictions:

Vacant building

Current year sale

Partial assessment

Prior equalization appraisal

Tax-exempt

Only one portion of a total property unit (example—a parking lot of a grocery store)

Value established by court action

Value is not more than \$5,000

Building on leased land

3. The department appraiser shall determine a substitute property if the originally selected one is ineligible. In ascending order, select code numbers until an eligible property is found.

EXAMPLE: If code number 2 is ineligible, use code number 3 as a substitute. If code number 3 is ineligible, use code number 4, etc., until an eligible property is found.

If the procedure described in 71.12(3) "c"(3)"3" moves the substitute property to a city or township, select substitute code numbers in descending order until an eligible property is found.

If the procedure described in the previous paragraph moves the substitute property to a preceding city or township, go back to the procedure of 71.12(3) "c"(3)"3" even if it moves the substitute property to a subsequent city or township.

4. Select an alternate property for the originally selected property which also would be eligible. This is necessary because at the time of appraisal the property may be found to be ineligible due to one of the restrictions in 71.12(3) "c"(3)"2." Alternate properties are selected by using the same procedure described in 71.12(3) "c"(3)"3."

5. Follow procedures 71.12(3) "c"(3), items "1" to "4," for each of the other originally selected sequence numbers.

71.12(4) Industrial real estate. It is not possible to determine the level of assessment of industrial real estate by using accepted equalization methods. The lack of sales data precludes the use of an assessment/sales ratio study, the diverse nature of industrial real estate precludes the use of a countywide or citywide income capitalization study, and the limited number of industrial properties precludes the use of sample appraisals. The level of assessment of industrial real estate can only be determined by the valuation of individual parcels of industrial real estate. Any attempt to equalize industrial valuations by using accepted equalization methods would create an arbitrary result. However, under the circumstances

set forth in Iowa Code subsection 421.17(10), the director may correct any errors in such assessments which are brought to the director's attention.

71.12(5) *Personal property.* Rescinded IAB 10/25/95, effective 11/29/95.

71.12(6) *Centrally assessed property.* Property assessed by the director of revenue pursuant to Iowa Code chapters 428 and 433 to 438, inclusive, is equalized internally by the director in the making of the assessments. Further, the assessments are equalized with the aggregate valuations of other classes of property as a result of actions taken by the director of revenue pursuant to rule 71.11(441).

71.12(7) *Miscellaneous real estate.* Since it is not possible to use accepted equalization methods to determine the level of assessment of mineral rights and interstate railroad and toll bridges, these classes of property shall not be subject to equalization by the director of revenue. However, under the circumstances set forth in Iowa Code section 421.17(10), the director may correct any errors in assessments which are brought to the director's attention.

This rule is intended to implement Iowa Code sections 441.21, 441.47, 441.48 and 441.49.
[ARC 7726B, IAB 4/22/09, effective 5/27/09; ARC 9478B, IAB 4/20/11, effective 5/25/11]

701—71.13(441) Tentative equalization notices. Prior to the issuance of the final equalization order to each county auditor, a tentative equalization notice providing for proposed percentage adjustments to the aggregate valuations of classes of property as set forth in rule 701—71.12(441) shall be mailed to the county auditor whose valuations are proposed to be adjusted. The tentative equalization notice constitutes the ten days' notice required by Iowa Code section 441.48.

This rule is intended to implement Iowa Code sections 441.47 and 441.48.

701—71.14(441) Hearings before the director.

71.14(1) *Protests.* Written or oral protest against the proposed percentage adjustments as set forth in the tentative equalization notice issued by the director of revenue shall be made only on behalf of the affected assessing jurisdiction. The protests shall be made only by officials of the assessing jurisdiction, including, but not limited to, an assessing jurisdiction's city council or board of supervisors, assessor, or city or county attorney. An assessing jurisdiction may submit a written protest in lieu of making an oral presentation before the director, or may submit an oral protest supported by written documentation. Protests against the adjustments in valuation contained in the tentative equalization notices shall be limited to a statement of the error or errors complained of and shall include such facts as might lead to their correction. No other factors shall be considered by the director in reviewing the protests. Protests and hearings on tentative equalization notices before the director are excluded from the provisions of the Iowa Administrative Procedure Act governing contested case proceedings.

71.14(2) *Conduct of hearing.* The director shall schedule each hearing so as to allow the same amount of time within which each assessing jurisdiction can make its presentation. During the hearing each assessing jurisdiction shall be afforded the opportunity to present evidence relevant to its protest. The director or the director's designated representative shall preside at the hearing which shall be held at the time and place designated by the director or such other time and place as may be mutually agreed upon by the director and the protesting assessing jurisdiction.

This rule is intended to implement Iowa Code section 441.48.

701—71.15(441) Final equalization order. After the tentative equalization notice has been issued and an opportunity for a hearing described in rule 71.14(441) has been afforded, the director shall issue a final equalization order by mail to the county auditor. The order shall specify any percentage adjustments in the aggregate valuations of any class of property to be made effective for the county as of January 1 of the year in which the order is issued. The final equalization order shall be issued on or before October 1 unless for good cause it cannot be issued until after October 1. The final equalization order shall be implemented by the county auditor.

An assessing jurisdiction may appeal a final equalization order to the state board of tax review. The protest must be filed or postmarked not later than ten days after the date the final equalization order is issued.

This rule is intended to implement Iowa Code sections 441.48 and 441.49.

701—71.16(441) Alternative method of implementing equalization orders.

71.16(1) *Application for permission to use an alternative method.* A request by an assessing jurisdiction for permission to use an alternative method of applying the final equalization order must be made in writing to the director of revenue within ten days from the date the county auditor receives the final equalization order. The written request shall include the following information:

a. Facts evidencing the need to use an alternative method of implementing the final equalization order. Such facts shall clearly show that the proposed method is essential to ensure compliance with the provisions of Iowa Code section 441.21.

b. The exact methods to be employed in implementing the requested alternative method for each class of property.

c. The specific method of notifying affected property owners of the valuation changes.

d. Evidence that the alternative method will result in an aggregate property class valuation adjustment equivalent to that prescribed in the director's final equalization order.

The director of revenue shall review each written request for an alternative method and shall notify the assessing jurisdiction of acceptance or rejection of the proposed method by October 15. The assessing jurisdiction shall immediately inform the county auditor of the director's decision. The county auditor shall include a description of any approved alternative method in the required newspaper publication of the final equalization order. In those instances where the approved alternative method includes individual property owner notification, the publication shall not be considered proper notice to the affected property owners.

71.16(2) *Implementation of alternative method.* If an alternative method is approved by the director of revenue, any individual notification of property owners shall be completed by the assessor by not later than October 25.

71.16(3) *Appeal by property owners.* If an alternative method is approved by the director of revenue, the special session of the local board of review to hear equalization protests shall be extended to November 30. In such instances, protests may be filed up to and including November 4.

This rule is intended to implement Iowa Code section 441.49.

701—71.17(441) Special session of boards of review.

71.17(1) *Grounds for protest.* The only ground for protesting to the local board of review reconvened in special session pursuant to Iowa Code section 441.49 is that the application of the director's final equalization order results in a value greater than that permitted under Iowa Code section 441.21.

71.17(2) *Authority of board of review.* When in special session to hear protests resulting from equalization adjustments, the local board of review shall only act upon protests for those properties for which valuations have been increased as a result of the application of the director of revenue's final equalization order.

The local board of review may adjust valuations of those properties it deems warranted, but under no circumstance shall the adjustment result in a value less than that which existed prior to the application of the director's equalization order. The local board of review shall not adjust the valuation of properties for which no protests have been filed.

71.17(3) *Report of board of review.* In the report to the director of revenue of action taken by the local board of review in special session, the board of review shall report the aggregate valuation adjustments by class of property as well as all other information required by the director of revenue to determine if such actions may have substantially altered the equalization order.

71.17(4) *Meetings of board of review.* If the final equalization order does not increase the valuation of any class of property, the board of review is not required to meet during the special session. If the final equalization order increases the valuation of one or more classes of property but no protests are filed by

the times specified in Iowa Code section 441.49, the board of review is not required to meet during the special session.

This rule is intended to implement Iowa Code sections 421.17(10) and 441.49.

701—71.18(441) Judgment of assessors and local boards of review. Nothing stated in these rules should be construed as prohibiting the exercise of honest judgment, as provided by law, by the assessors and local boards of review in matters pertaining to valuing and assessing of individual properties within their respective jurisdictions.

This rule is intended to implement Iowa Code sections 441.17 and 441.35.

701—71.19(441) Conference boards.

71.19(1) Establishment and abolition of office.

a. As referred to in Iowa Code section 441.1, the term “federal census” includes any special census conducted by the Bureau of the Census of the U.S. Department of Commerce as well as the Bureau’s decennial census.

b. Within 60 days of receiving the certified results of a federal census indicating the population of a city having its own assessor has fallen below 10,000, the city council of the city shall repeal the ordinance providing for its own assessor.

c. Whenever the office of city assessor is abolished, all moneys in the assessment expense fund and the special appraiser fund shall be transferred to the appropriate accounts in the county assessor’s office, and all equipment and supplies shall be transferred to the county assessor’s office. Employees of the city assessor’s office may, at the discretion of the county assessor, become employees of the county assessor. However, any deputy assessor of the city may not be appointed a deputy county assessor unless certified as eligible for appointment pursuant to Iowa Code sections 441.5 and 441.10.

71.19(2) Membership.

a. County conference boards. A county conference board consists of the county board of supervisors, the mayor of each incorporated city in the county whose property is assessed by the county assessor, and one member of the board of directors of each high school district in the county, provided the member is a resident of the county. Members representing school districts serve one-year terms, and the board of directors each year must notify the clerk of the conference board of its representative on the conference board. A member of the board of directors of a school district may serve on the county conference board even though the member lives in a city having its own assessor (1978 O.A.G. 466).

b. City conference boards. A city conference board consists of the county board of supervisors, the city council, and the entire board of directors of each school district whose property is assessed by the city assessor.

71.19(3) Voting.

a. Votes on matters before a conference board shall be by units as provided in Iowa Code section 441.2. At least two members of each voting unit must be present in order for the unit to cast a vote (1960 O.A.G. 226). In the event the vote of the members of a voting unit ends in a tie, that unit shall not cast a vote on the particular matter before the conference board.

b. If a member of a conference board is absent from a meeting, the member’s vote may not be cast by another person, except that a mayor pro tem as provided in Iowa Code section 372.14(3) may vote for the mayor when the mayor is absent from or unable to perform official duties.

This rule is intended to implement Iowa Code section 441.2.

701—71.20(441) Board of review.

71.20(1) Membership.

a. Occupation of members. One member of the county board of review must be actively engaged in farming as that member’s primary occupation. However, it is not necessary for a board of review to have as a member one licensed real estate broker and one registered architect or person experienced in the building and construction field if the person cannot be located after a good faith effort to do so has been made by the conference board (1966 O.A.G. 416). In determining eligibility for membership on

a board of review, a retired person is not considered to be employed in the occupation pursued prior to retirement, unless that person remains in reasonable contact with the former occupation, including some participation in matters associated with that occupation.

b. Residency of members. A person must be a resident of the assessor jurisdiction served to qualify for appointment as a member of the board of review. However, a member changing assessing jurisdiction residency after appointment to the board may continue to serve on the board until the member's current term of office expires.

c. Term of office. The term of office of members of boards of review shall be for six years and shall be staggered as provided in Iowa Code section 441.31. In the event of the death, resignation, or removal from office of a member of a board of review, the conference board or city council shall appoint a successor to serve the unexpired term of the previous incumbent.

d. Membership on other boards. A member of a board of review shall not at the same time serve on either the conference board or the examining board, or be an employee of the assessor's office (1948 O.A.G. 120, 1960 O.A.G. 226).

e. Number of members. A conference board or city council may at any time change the composition of a board of review to either three or five members. To reduce membership from five members to three members, the conference board or city council shall not appoint successors to fill the next two vacancies which occur (1970 O.A.G. 342). To increase membership from three members to five members, the conference board or city council shall appoint two additional members whose initial terms shall expire at such times so that no two board members' terms expire at the end of the same year. Also, the conference board or city council may increase the membership of the board of review by an additional two members if it determines that a large number of protests warrant the emergency appointments. If the board of review has ten members, not more than four additional members may be appointed by the conference board. The terms of the emergency members will not exceed two years.

f. Removal from office. A member of a board of review may be removed from office by the conference board or city council but only after specific charges have been filed by the conference board or city council.

g. Appointment of members. Members of a county board of review shall be appointed by the county conference board. Members of a city board of review shall be appointed by the city conference board in cities with an assessor or by the city council in cities without an assessor. A city without an assessor can only have a board of review if the population of the city is 75,000 or more. A city with a population of more than 125,000 may appoint a city board of review or request the county conference board to appoint a ten-member county board of review.

71.20(2) Sessions of boards of review.

a. It is mandatory that a board of review convene on May 1 and adjourn no later than May 31 of each year. However, if either date falls on a Saturday, Sunday, or legal holiday, the board of review shall convene or adjourn on the following Monday.

b. Extended session. If a board of review determines it will be unable to complete its work by May 31, it may request that the director of revenue extend its session up to July 15. The request must be signed by a majority of the membership of the board of review and must contain the reasons the board of review cannot complete its work by May 31. During the extended session, a board of review may perform the same functions as during its regular session unless specifically limited by the director of revenue.

c. Special session. If a board of review is reconvened by the director of revenue pursuant to Iowa Code section 421.17, the board of review shall perform those functions specified in the order of the director of revenue and shall perform no other functions.

71.20(3) Actions initiated by boards of review.

a. Internal equalization of assessments. A board of review in reassessment years as provided in Iowa Code section 428.4 has the power to equalize individual assessments as established by the assessor, but cannot make percentage adjustments in the aggregate valuations of classes of property (1966 O.A.G. 416). In nonreassessment years, a board of review can adjust the valuation of an entire class of property

by adjusting all assessment by a uniform percentage. Nothing contained in this rule shall restrict the director from exercising the responsibilities set forth in Iowa Code section 421.17.

b. Omitted assessments. A board of review may assess for taxation any property which was not assessed by the assessor, including property which the assessor determines erroneously is not subject to taxation by virtue of enjoying an exempt status (*Talley v. Brown*, 146 Iowa 360,125 N.W. 248 (1910)).

c. Notice to taxpayers. If the value of any property is increased by a board of review or a board of review assesses property not previously assessed by the assessor, the person to whom the property is assessed shall be notified by regular mail of the board's action. The notification shall state that the taxpayer may protest the action by filing a written protest with the board of review within five days of the date of the notice. After at least five days have passed since notifying the taxpayer, the board of review shall meet to take final action on the matter, including the consideration of any protest filed. However, if the valuations of all properties within a class of property are raised or lowered by a uniform percentage in a nonreassessment year, notice to taxpayers need be provided only by newspaper publication as described in Iowa Code section 441.35.

71.20(4) Appeals to boards of review.

a. A board of review may act only upon written protests which have been filed with the board of review between April 16 and May 5, inclusive. In the event May 5 falls on a Saturday or Sunday, protests filed the following Monday shall be considered to have been timely filed. Protests postmarked by May 5 or the following Monday if May 5 falls on a Saturday or Sunday shall also be considered to have been timely filed. All protests must be in writing and signed by the taxpayer or the taxpayer's authorized agent. A written request for an oral hearing must be made at the time of filing the protest and may be made by checking the appropriate box on the form prescribed by the department of revenue. Protests may be filed for previous years if the taxpayer discovers that a mathematical or clerical error was made in the assessment, provided the taxes have not been fully paid or otherwise legally discharged. The protester may combine on one form assessment protests on parcels separately assessed if the same grounds are relied upon as the basis for protesting each separate assessment. If an oral hearing is requested on more than one of the protests, the person making the combined protests may request that the oral hearings be held consecutively. A board of review may allow protests to be filed in electronic format. Protests transmitted electronically are subject to the same deadlines as written protests.

b. Grounds for protest. Taxpayers may protest to a board of review on one or more of the grounds specified in Iowa Code section 441.37. The grounds for protest and procedures for considering protests are as follows:

(1) The assessment is not equitable when compared with those of similar properties in the same assessing district. If this ground is a basis for the protest, the protest must contain the legal descriptions and assessments of the comparable properties. The comparable properties selected by the taxpayer must be located within the same assessing district as the property for which the protest has been filed (*Maytag Co. v. Partridge*, 210 N.W.2d 584 (Iowa 1973)). In considering a protest based upon this ground, the board of review should examine carefully all information used to determine the assessment of the subject property and the comparable properties and determine that those properties are indeed comparable to the subject property. It is the responsibility of the taxpayer to establish that the other properties submitted are comparable to the subject property and that inequalities exist in the assessments (*Chicago & N. W. Ry. Co. v. Iowa State Tax Commission*, 257 Iowa 1359,137 N.W.2d 246(1965)).

(2) The property is assessed at more than its actual value as defined in Iowa Code section 441.21. If this ground is used, the taxpayer must state both the amount by which the property is overassessed and the amount considered to be the actual value of the property.

(3) The property is not assessable and should be exempt from taxation. If using this ground, taxpayers must state the reasons why it is felt the property is not assessable.

(4) There is an error in the assessment. An error in the assessment would most probably involve erroneous mathematical computations or errors in listing the property. The improper classification of property also constitutes an error in the assessment. If this ground is used, the taxpayer's protest must state the specific error alleged.

A board of review must determine:

1. If an error exists, and
2. How the error might be corrected.

(5) There is fraud in the assessment. If this ground of protest is used, the taxpayer's protest must state the specific fraud alleged, and the board of review must first determine if there is validity to the taxpayer's allegation. If it is determined there is fraud in the assessment, the board of review shall take action to correct the assessment and report the matter to the director of revenue.

(6) There has been a change of value of real estate since the last assessment. The board of review must determine that the value of the property as of January 1 of the current year has changed since January 1 of the previous reassessment year. This is the only ground upon which a protest pertaining to the valuation of a property can be filed in a year in which the assessor has not assessed or reassessed the property pursuant to Iowa Code section 428.4. In a year subsequent to a year in which a property has been assessed or reassessed pursuant to Iowa Code section 428.4, a taxpayer cannot protest to the board of review based upon actions taken in the year in which the property was assessed or reassessed (*James Black Dry Goods Co. v. Board of Review for City of Waterloo*, 260 Iowa 1269, 151 N.W.2d 534 (1967); *Commercial Merchants Nat'l Bank and Trust Co. v. Board of Review of Sioux City*, 229 Iowa 1081, 296 N.W. 203 (1941)).

c. Disposition of protests. After reaching a decision on a protest, the board of review shall give the taxpayer written notice of its decision. The notice shall contain the following information:

- (1) The valuation and classification of the property as determined by the board of review.
- (2) If the protest was based on the ground the property was not assessable, the notice shall state whether the exemption is allowed and the value at which the property would be assessed in the absence of the exemption.
- (3) The specific reasons for the board's decision with respect to the protest.

(4) That the board of review's decision may be appealed to the district court within 20 days of the board's adjournment or May 31, whichever date is later. If the adjournment date is known, the date shall be stated on the notice. If the adjournment date is not known, the notice shall state the date will be no earlier than May 31. Notice of the appeal shall be served on the chairperson, presiding officer, or clerk of the board of review after the written notice of appeal has been filed with the clerk of district court.

This rule is intended to implement Iowa Code sections 441.31 to 441.37 and Iowa Code Supplement section 441.38 as amended by 2006 Iowa Acts, House File 2794.

701—71.21(421,17A) Property assessment appeal board.

71.21(1) Establishment, membership, and location of the property assessment appeal board.

a. A statewide property assessment appeal board is created for the purpose of establishing a consistent, fair, and equitable property assessment appeal process. The statewide property assessment appeal board is established within the department of revenue. The board's principal office shall be in the office of the department of revenue.

b. The property assessment appeal board shall consist of three members appointed by the governor and subject to confirmation by the senate. The members shall be appointed to staggered six-year terms beginning initially on January 1, 2007, and ending as provided in Iowa Code section 69.19. Members' subsequent terms shall begin and end as provided in Iowa Code section 69.19. The governor shall appoint from the members a chairperson, subject to confirmation by the senate, of the board to a two-year term. Vacancies on the board shall be filled for the unexpired portion of the term in the same manner as regular appointments are made.

Each member of the property assessment appeal board shall be qualified by virtue of at least two years' experience in the area of government, corporate, or private practice relating to property appraisal and property tax administration. One member of the board shall be a certified real estate appraiser or hold a professional appraisal designation, one member shall be an attorney practicing in the area of state and local taxation or property tax appraisals, and one member shall be a professional with experience in the field of accounting or finance and with experience in state and local taxation matters. No more than two members of the board may be from the same political party as that term is defined in Iowa Code section 43.2.

c. The property assessment appeal board shall organize by appointing a secretary who shall take the same oath of office as the members of the board. The board may employ additional personnel as it finds necessary. All personnel employed by the board shall be considered state employees and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

71.21(2) Powers and duties of the board. The property assessment appeal board shall:

a. Review any final decision, finding, ruling, determination, or order of a local board of review relating to assessment protests, valuation, or application of an equalization order.

b. Affirm, reverse, or modify a final decision, finding, ruling, determination, or order of a local board of review.

c. Order the payment or refund of property taxes in a matter over which the board has jurisdiction.

d. Grant other relief or issue writs, orders, or directives that the board deems necessary or appropriate in the process of disposing of a matter over which the board has jurisdiction.

e. Subpoena documents and witnesses and administer oaths.

f. Adopt administrative rules pursuant to Iowa Code chapter 17A for the administration and implementation of its powers, including rules for practice and procedure for protests filed with the board, the manner in which hearings on appeals of assessments shall be conducted, filing fees to be imposed by the board, and for the determination of the correct assessment of property which is the subject of an appeal.

g. Adopt administrative rules pursuant to Iowa Code chapter 17A necessary for the preservation of order and the regulation of proceedings before the board, including forms or notice and the service thereof, which rules shall conform as nearly as possible to those in use in the courts of this state.

h. If an appeal to district court is taken from the action of the property assessment appeal board, notice of appeal shall be served as an original notice on the secretary of the board after the written notice of appeal has been filed with the clerk of district court.

71.21(3) General counsel. The property assessment appeal board shall employ a competent attorney to serve as its general counsel, and assistants to the general counsel as it finds necessary for the full and efficient discharge of its duties. The general counsel is the attorney for, and legal advisor of, the board. The general counsel or an assistant to the general counsel shall provide the necessary legal advice to the board in all matters and shall represent the board in all actions instituted in a court challenging the validity of a rule or order of the board. The general counsel shall devote full time to the duties of the office. During employment as general counsel to the board, the counsel shall not be a member of a political committee, contribute to a political campaign, participate in a political campaign, or be a candidate for partisan political office. The general counsel and assistants to the general counsel shall be considered state employees and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

71.21(4) Compensation. The members of the property assessment appeal board shall receive compensation from the state commensurate with the salary of a district judge. The members of the board shall be considered state employees for purposes of salary and benefits and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV. Members of the board and any employees of the board, when required to travel in the discharge of official duties, shall be paid their actual and necessary expenses incurred in the performance of their duties.

71.21(5) Appeal board review committee. Effective January 1, 2012, a property assessment appeal board review committee is established. Staffing assistance to the committee shall be provided by the department of revenue. The committee shall consist of six members of the general assembly, two appointed by the majority leader of the senate, one appointed by the minority leader of the senate, two appointed by the speaker of the house of representatives, and one appointed by the minority leader of the house of representatives; the director of revenue or the director's designee; a county assessor appointed by the Iowa state association of counties; and a city assessor appointed by the Iowa league of cities.

The property assessment appeal board review committee shall review the activities of the property assessment appeal board since its inception. The review committee may recommend the revision of any rules, regulations, directives, or forms relating to the activities of the property assessment appeal board.

The review committee shall report to the general assembly by January 15, 2013. The report shall include any recommended changes in laws relating to the property assessment appeal board, the reasons for the committee’s recommendations, and any other information the committee deems advisable.

71.21(6) Applicability and scope. These subrules set forth herein govern the proceedings for all cases in which the property assessment appeal board (board) has jurisdiction to hear appeals from the action of a local board of review. For the purpose of these subrules, the following definitions shall apply:

“*Appellant*” means the party filing the notice of appeal with the secretary of the property assessment appeal board.

“*Board*” means the property assessment appeal board as created by chapter 150 of the Acts of the Eighty-first General Assembly and governed by Iowa Code chapter 17A and sections 421.1A and 441.37A.

“*Department*” means the Iowa department of revenue.

“*Local board of review*” means the board of review as defined by Iowa Code section 441.31.

“*Party*” means a property owner, an aggrieved taxpayer, an assessor, an appellant or an appellee in an appeals process before the board.

“*Presiding officer*” means the chairperson, member or members of the property assessment appeal board who preside over an appeal of proceedings before the property assessment appeal board.

“*Secretary*” means the secretary for the property assessment appeal board.

71.21(7) Appeal and jurisdiction. Notice of appeal confers jurisdiction for the board. The procedure for appeals and parameters for jurisdiction are as follows:

a. Jurisdiction is conferred upon the board by written notice of appeal given to the secretary. The written notice of appeal shall include a petition setting forth the basis of the appeal and the relief sought. The written notice of appeal shall be filed with the secretary within 20 days after the postmarked date of the disposition of the protest by the local board of review. Appeals postmarked within 20 days after the postmarked date of the disposition of the protest by the local board of review shall also be considered to have been timely filed. The appellant may appeal the action of the board of review relating to protests of assessment, valuation, or the application of an equalization order. A party may request to participate by telephone in any hearing before the board.

b. The notice of appeal must be proper in format and content as set forth in subrule 71.21(9), which governs the notice of appeal. Notice of appeal may be delivered in person, mailed by first-class mail, or delivered to an established courier service for immediate delivery to the secretary of the board. The mailing address for the board is Secretary of the Property Assessment Appeal Board, 401 SW 7th Street, Suite D, Des Moines, Iowa 50309-4634.

71.21(8) Scope of review. The board shall determine anew all questions arising before the local board of review which relate to the liability of the property to assessment or the amount thereof. The board will consider only those grounds set out in the protest to the local board of review. However, additional evidence may be introduced in the board proceedings relevant to the grounds set out in the protest. The board shall afford each party an opportunity to present briefs and oral arguments. There shall be no presumption as to the correctness of the valuation of the assessment appealed from.

71.21(9) Form of appeal. The written notice of appeal shall contain a caption in the following form:

THE PROPERTY ASSESSMENT APPEAL BOARD
401 SW 7th STREET, SUITE D
DES MOINES, IOWA 50309-4634

IN THE MATTER OF _____
(Appellant’s name and address)



NOTICE OF APPEAL and PETITION
DOCKET NO. _____
(Docket No. assigned by board)

The notice of appeal shall include:

- a. The appellant’s name and mailing address;
- b. A copy of the petition to the local board of review;

- c. Copies of all evidence submitted to the local board of review in support of the petition to the local board of review;
- d. A copy of the postmarked envelope and a copy of the letter of disposition by the local board of review;
- e. A short and plain statement of the claim showing that the appellant is entitled to relief;
- f. The relief sought; and
- g. The signature of the appealing party or the party's legal representative.

To have legal representation before the board, a party must file a valid and complete power of attorney form as provided by the board or in compliance with the power of attorney form provided by the board.

71.21(10) Notice to local board of review. The secretary shall mail a copy of the appellant's written notice of appeal and petition to the local board of review whose decision is being appealed. Notice to all affected taxing districts shall be deemed to have been given when written notice is provided to the local board of review.

71.21(11) Certification by local board of review. Within 14 days after notice of appeal is given, the local board of review shall certify to the board all records, documents, or reports, or disposition order or directive from which an appeal is taken, the complete property record card for the subject property, the protest hearing minutes of the local board of review kept pursuant to Iowa Code chapter 21, and all other pertinent information.

The local board of review shall submit to the board in writing the name, address, and telephone number of the attorney representing the local board of review before the board. The local board of review may make a written request for additional time to certify a copy of its record to the board.

71.21(12) Docketing. Appeals shall be assigned consecutive docket numbers. Records consisting of the case name and the corresponding docket number assigned to the case must be maintained by the secretary. The records of each case shall also include each action and each act done, with the proper dates as follows:

- a. The title of the appeal including jurisdiction and parcel identification number;
- b. Brief statement of the grounds for the appeal and the relief sought;
- c. Postmarked date of the local board of review's letter of disposition;
- d. The manner and date/time of service of notice of appeal;
- e. Date of notice of hearing;
- f. Date of hearing; and
- g. The decision by the board, or other disposition of the case, and date thereof.

71.21(13) Appearances. A party may appear in person, by legal representative or through an attorney. In order to be considered the legal representative before the board, a valid power of attorney form as provided by the board or in compliance with the power of attorney form provided by the board must be properly completed and filed with the board. An attorney shall file an appearance. All orders, correspondence, or other documents shall be served on the designated individual.

71.21(14) Filing of papers. After the notice of appeal and petition have been filed, either in person, mailed by first-class mail, or delivered to an established courier service for immediate delivery, all motions, pleadings, briefs, and other papers to be filed shall be filed with the secretary at 401 SW 7th Street, Suite D, Des Moines, Iowa 50309-4634. Motions, pleadings, briefs, and other papers to be filed with the board shall be delivered in person, mailed by first-class mail, or delivered to an established courier service. Parties shall also send copies to all other parties of record, unless represented by counsel of record, and then to such counsel.

- a. For most filings in a docket made with the board, only an original is required.
- b. For exhibits and other documents to be introduced at hearing, an original plus two copies are required.
- c. The board or presiding officer may request additional copies.

71.21(15) Motions. All motions shall be in writing, shall be filed with the secretary and shall contain the reasons and grounds supporting the motion. The board shall act upon such motions as justice may require. Motions based on matters which do not appear of record shall be supported by affidavit. Any

party may file a written response to a motion no later than 10 days from the date the motion is filed, unless the time period is extended or shortened by the board or presiding officer.

71.21(16) Authority of board to issue procedural orders. The board may issue preliminary orders regarding procedural matters. The secretary shall mail copies of all procedural orders to the parties.

71.21(17) Members participating. An appeal may be reviewed and considered by less than a majority of the members of the board, and the chairperson of the board may assign members to consider appeals. Orders and decisions shall be signed by one member of the board and shall name participating members. Decisions shall affirm, modify, or reverse the decision, order, or directive from which an appeal was made. In order for the decision to be valid, a majority of the board must concur on the decision on appeal.

71.21(18) Notice of hearing. Unless otherwise designated by the board, the hearing shall be held in the hearing room of the board at 401 SW 7th Street, Suite D, Des Moines, Iowa. All hearings are open to the public. If a hearing is requested, the secretary shall mail a notice of hearing to the parties at least 30 days prior to the hearing. The notice of hearing shall contain the following information:

- a. A statement of the date, time, and place of the hearing;
- b. A statement of legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;
- d. That the parties may appear and present oral arguments;
- e. That the parties may submit evidence and briefs;
- f. That the hearing will be electronically recorded by the board;
- g. That a party may obtain a certified court reporter for the hearing at the party's own expense;
- h. That audio visual aids and equipment are to be provided by the party intending to use them;
- i. A statement that, upon submission of the appeal, the board will take the matter under advisement. A letter of disposition will be mailed to the parties; and
- j. A compliance notice required by the Americans with Disabilities Act (ADA).

71.21(19) Transcript of hearing. All hearings shall be electronically recorded. Any party may provide a certified court reporter at the party's own expense. Any party may request a transcription of the hearing. The board reserves the right to impose a charge for copies and transcripts.

71.21(20) Continuance. Any hearing may be continued for "good cause." Requests for continuance prior to the hearing shall be in writing and promptly filed with the secretary of the board immediately upon "the cause" becoming known. An emergency oral continuance may be obtained from the board or presiding officer based on "good cause" and at the discretion of the board or presiding officer. In determining whether to grant a continuance, the board or presiding officer may consider:

- a. Prior continuances;
- b. The interests of all parties;
- c. The likelihood of informal settlement;
- d. The existence of an emergency;
- e. Any objection;
- f. Any applicable time requirements;
- g. The existence of a conflict in the schedules of counsel, parties, or witnesses;
- h. The timeliness of the request; and
- i. Other relevant factors.

71.21(21) Telephone proceedings. The board, at its discretion and based on "good cause," may conduct a telephone conference in which all parties have an opportunity to participate. The board will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when the location is chosen.

71.21(22) Disqualification of board member. A board member or members must, on their own motion or on a motion from a party in the proceeding, withdraw from participating in an appeal if there are circumstances that warrant disqualification.

- a. A board member or members shall withdraw from participation in the making of any proposed or final decision in an appeal before the board if that member is involved in one of the following circumstances:

- (1) Has a personal bias or prejudice concerning a party or a representative of a party;
 - (2) Has personally investigated, prosecuted, or advocated in connection with the appeal, the specific controversy underlying that appeal, or another pending factually related matter, or a pending factually related controversy that may culminate in an appeal involving the same parties;
 - (3) Is subject to the authority, direction, or discretion of any person who has personally investigated, prosecuted, or advocated in connection with that matter, the specific controversy underlying the appeal, or a pending factually related matter or controversy involving the same parties;
 - (4) Has acted as counsel to any person who is a private party to that proceeding within the past two years;
 - (5) Has a personal financial interest in the outcome of the appeal or any other significant personal interest that could be substantially affected by the outcome of the appeal;
 - (6) Has a spouse or relative within the third degree of relationship who:
 1. Is a party to the appeal, or an officer, director or trustee of a party;
 2. Is a lawyer in the appeal;
 3. Is known to have an interest that could be substantially affected by the outcome of the appeal;
- or
4. Is likely to be a material witness in the appeal; or
 - (7) Has any other legally sufficient cause to withdraw from participation in the decision making in that appeal.

b. Motion for disqualification. If a party asserts disqualification on any appropriate ground, including those listed in paragraph “*a*,” the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.11. The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification, but must establish the grounds by the introduction of evidence into the record.

If a majority of the board determines that disqualification is appropriate, the board member shall withdraw. If a majority of the board determines that withdrawal is not required, the board shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and a stay as provided under 701—Chapter 7.

c. The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other functions of the board, including fact gathering for purposes other than investigation of the matter which culminates in an appeal. Factual information relevant to the merits of an appeal received by a person who later serves as presiding officer or a member of the board shall be disclosed if required by Iowa Code section 17A.11 and this rule.

d. Withdrawal. In a situation where a presiding officer or any other board member knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

71.21(23) Consolidation and severance. A majority of the board may determine, in its discretion, if consolidation or severance of issues or proceedings should be performed in order to efficiently resolve matters on appeal before the board.

a. Consolidation. The presiding officer may consolidate any or all matters at issue in two or more appeal 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 involved; and
- (3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

b. Severance. The presiding officer may, for good cause shown, order any appeal proceedings or portions of the proceedings severed.

71.21(24) *Withdrawal.* An appellant may withdraw the appeal prior to the hearing. Such a withdrawal of an appeal must be in writing and signed by the appellant or the appellant's legal representative. Unless otherwise provided, withdrawal shall be with prejudice and the appellant shall not be able to refile the appeal. Within 20 days of the board granting a withdrawal of appeal, the appellant may make a motion to reopen the file and rescind the withdrawal based upon fraud, duress, undue influence, or mutual mistake.

71.21(25) *Prehearing conference.* An informal conference of parties may be ordered at the discretion of the board or presiding officer or at the request of any party for any appropriate purpose. Any agreement reached at the conference shall be made a part of the record in the manner directed by the board or presiding officer.

71.21(26) *Hearing procedures.* A party to the appeal may request a hearing, or the appeal may proceed without a hearing. The local board of review may be present and participate at such hearing.

a. Authority of presiding officer. The presiding officer presides at the hearing and may rule on motions, require briefs, issue a decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

b. Representation. Parties to the appeal have the right to participate or to be represented in all hearings. Any party may be represented by an attorney or another person authorized by law. To have legal representation before the board, a party must complete a power of attorney form as provided by the board or in compliance with the power of attorney form provided by the board.

c. Participation in hearing. The parties to the appeal have the right to introduce evidence relevant to the grounds set out in the protest to the local board of review. Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

d. Decorum. The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

e. Conduct of the hearing. The presiding officer shall conduct the hearing in the following manner:

(1) The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

(2) The parties shall be given an opportunity to present opening statements;

(3) The parties shall present their cases in the sequence determined by the presiding officer;

(4) Each witness shall be sworn or affirmed by the presiding officer and shall be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law; and

(5) When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

71.21(27) *Discovery*

a. Discovery procedure. Discovery procedures applicable in civil actions are available to parties in cases before the board. Unless lengthened or shortened by these rules, the board or presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

b. Discovery motions. Prior to filing any motion related to discovery, parties shall make a good-faith effort to resolve discovery disputes without the involvement of the board or presiding officer. Any motion related to discovery shall allege that the moving party has made a good-faith attempt to resolve the discovery issues involved with the opposing party. Opposing parties shall be given the opportunity to respond within 10 days of the filing of the motion unless the time is shortened by order of the board or presiding officer. The board or presiding officer may rule on the basis of the written motion and any response or may have a hearing or other proceedings on the motion.

c. Admissibility of evidence. Evidence obtained in discovery may be used in the case proceeding if that evidence would otherwise be admissible in that proceeding.

71.21(28) Subpoenas*a. Issuance of Subpoena for Witness.*

(1) An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In absence of good cause for permitting later action, a request for subpoena must be received at least 10 days before the scheduled hearing.

(2) Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

b. Issuance of Subpoena for Production of Documents.

(1) An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In absence of good cause for permitting later action, a request for subpoena must be received at least 20 days before the scheduled hearing.

(2) Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas.

c. Motion to quash or modify. Upon motion, the board or presiding officer may quash or modify a subpoena for any lawful reason.

71.21(29) Evidence.

a. Admissibility. The presiding officer shall rule on admissibility of evidence and may take official notice of facts in accordance with all applicable requirements of law.

b. Stipulations. Stipulation of facts by the parties is encouraged. The presiding officer may make a decision based on stipulated facts.

c. Scope of admissible evidence. Evidence in the proceeding shall be confined to the issues contained in the notice from the board prior to the hearing, unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. Admissible evidence is that which, in the opinion of the board, is determined to be material, relevant, or necessary for the making of a just decision. Irrelevant, immaterial or unduly repetitious evidence may be excluded. A finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Hearsay evidence is admissible. The rules of privilege apply in all proceedings before the board.

d. Exhibits and briefs. The party seeking admission of an exhibit must provide an opposing party with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents to be used as evidence shall be provided to the opposing party at least 10 days prior to the hearing, unless the time period is extended or shortened by the board or presiding officer. All exhibits and briefs admitted into evidence shall be appropriately marked and be made part of the record. The appellant shall mark exhibits with consecutive numbers. The appellee shall mark exhibits with consecutive letters.

e. Objections. Any party may object to specific evidence or may request limits on the scope of examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which the objection is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

f. Offers of proof. Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

71.21(30) Settlements. Parties to a case may propose to settle all or some of the issues in the case at any time prior to the issuance of a final decision. The board or presiding officer will not approve settlements unless the settlement is reasonable in light of the whole record, consistent with law, and in the public interest. Board adoption of a settlement constitutes the final decision of the board on issues addressed in the settlement.

71.21(31) Appeals records. The record of the appeal is maintained at the office of the board. Unless the record is held confidential, parties and members of the public may examine the record and obtain copies of documents.

71.21(32) Motion to reopen records. The board or presiding officer, on the board's or presiding officer's own motion or on the motion of a party, may reopen the record for the reception of further evidence. A motion to reopen the record may be made anytime prior to the issuance of a final decision.

71.21(33) Rehearing and reconsideration.

a. Application for rehearing or reconsideration. Any party to a case may file an application for rehearing or reconsideration of the final decision. The application for rehearing or reconsideration shall be filed within 20 days after the final decision in the case is issued.

b. Contents of application. Applications for rehearing or reconsideration shall specify the findings of fact and conclusions of law claimed to be erroneous, with a brief statement of the alleged grounds of error. Any application for rehearing or reconsideration asserting that evidence has arisen since the final order was issued as a ground for rehearing or reconsideration shall present the evidence by affidavit that includes an explanation of the competence of the person to sponsor the evidence and a brief description of the evidence sought to be included.

c. Notice to other parties. A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

d. Requirements for objections to applications for rehearing or reconsideration. An answer or objection to an application for rehearing or reconsideration must be filed within 14 days of the date the application was filed with the board, unless otherwise ordered by the board.

e. Disposition. Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

71.21(34) Dismissal. If a party fails to appear or participate in an appeal hearing after proper service of notice, the presiding officer may dismiss the appeal unless a continuance is granted for good cause. If an appeal is dismissed for failure to appear, the board shall have no jurisdiction to consider any subsequent appeal on the appellant's protest.

71.21(35) Waivers.

a. In response to a request, or on its own motion, the board may grant a waiver from a rule adopted by the board, in whole or in part, as applied to a specific set of circumstances, if the board finds, based on clear and convincing evidence, that:

(1) The application of the rule would pose an undue hardship on the person for whom the waiver is requested;

(2) The waiver would not prejudice the substantial rights of any person;

(3) The provisions of the rule subject to a petition for waiver are not specifically mandated by statute or another provision of law; and

(4) Substantially equal protection of public health, safety, and welfare will be afforded by means other than that prescribed in the rule for which the waiver is requested.

b. Persons requesting a waiver may submit their request in writing. The waiver request must state the relevant facts and reasons the requester believes will justify the waiver, if the reasons have not already been provided to the board in another pleading.

c. Grants or denials of waiver requests shall contain a statement of the facts and reasons upon which the decision is based. The board may condition the grant of the waiver on such reasonable conditions as appropriate to achieve the objectives of the particular rule in question. The board may at any time cancel a waiver upon appropriate notice and opportunity for hearing.

71.21(36) Appeals of board decisions. A party may seek judicial review of a decision rendered by the board by filing a written notice of appeal with the clerk of the district court within 20 days after the letter of disposition of the appeal by the board is mailed to the appellant.

71.21(37) Time requirements. Time shall be computed as provided in Iowa Code section 4.1(34).

71.21(38) *Judgment of the board.* Nothing stated in this rule should be construed as prohibiting the exercise of honest judgment, as provided by law, by the board in matters pertaining to valuation and assessment of individual properties.

This rule is intended to implement Iowa Code sections 421.1, 421.1A, 421.2, 441.37A, 441.38 and 441.49 and chapter 17A.

701—71.22(428,441) Assessors.

71.22(1) *Conflict of interest.* An assessor shall not act as a private appraiser, or as a real estate broker or option agent in the jurisdiction in which serving as assessor (1976 O.A.G. 744).

71.22(2) *Listing of property.*

a. Forms. Assessors may design and use their own forms in lieu of those prescribed by the department of revenue provided that the forms contain all information contained on the prescribed form, are not substantially different from the prescribed form, and are approved by the director of revenue.

b. Assessment rolls. Assessment rolls must be prepared in duplicate for each property in a reassessment year as defined in Iowa Code section 428.4. However, the copy of the roll does not have to be issued to a taxpayer unless there is a change in the assessment or the taxpayer requests the issuance of the duplicate copy.

c. Whenever a date specified in Iowa Code chapter 441 falls on a Saturday, Sunday, or legal holiday, the action required to be completed on or before that date shall be considered to have been timely completed if performed on or before the following day which is not a Saturday, Sunday, or holiday.

d. Buildings erected or improvements made by a person other than the owner of the land on which they are located are to be assessed to the owner of the buildings or improvements. Unpaid taxes are a lien on the buildings or improvements and not a lien on the land on which they are located.

71.22(3) *Notice of protest.* If a protest or appeal is filed with the board of review, property assessment appeal board, or district court against the assessment of property valued at \$5 million or more, the assessor shall provide notice to the school district in which the property is located within ten days of the filing of the protest or the appeal, as applicable.

This rule is intended to implement Iowa Code chapter 428 and Iowa Code chapter 441 as amended by 2006 Iowa Acts, House File 2797.

701—71.23 and 71.24 Reserved.

701—71.25(441,443) Omitted assessments.

71.25(1) *Property subject to omitted assessment.*

a. Land and buildings. An omitted assessment can be made only if land or buildings were not listed and assessed by the assessor. The failure to list and assess an entire building is an omission for which an omitted assessment can be made even if the land upon which the building is located has been listed and assessed. See *Okland v. Bilyeu*, 359 N.W.2d 412 (Iowa 1984). However, the failure to consider the value added as a result of an improvement made does not constitute an omission for which an omitted assessment can be made if the building or land to which the improvement was made has been listed and assessed.

b. Previously exempt property. Property which has been erroneously determined to be exempt from taxation may be restored to taxation by the making of an omitted assessment. See *Talley v. Brown*, 146 Iowa 360, 125 N.W. 243 (1910). An omitted assessment is also made to restore to taxation previously exempt property which ceases to be eligible for an exemption.

71.25(2) *Officials authorized to make an omitted assessment.*

a. Local board of review. A local board of review may make an omitted assessment of property during its regular session only if the property was not listed and assessed as of January 1 of the current assessment year. For example, during its regular session which begins May 1, 1986, a local board of review may make an omitted assessment only of property that was not assessed by the assessor as of January 1, 1986. During that session, the board of review could not make an omitted assessment for an assessment year prior to 1986.

b. County auditor and local assessor. The county auditor and local assessor may make an omitted assessment. However, no omitted assessment can be made by the county auditor or local assessor if taxes based on the assessment year in question have been paid or otherwise legally discharged. For example, if a tract of land was listed and assessed and taxes levied against that assessment have been paid or legally discharged, no omitted assessment can be made of a building located upon that tract of land even though the building was not listed and assessed at the time the land was listed and assessed. See *Okland v. Bilyeu*, 359 N.W.2d 412, 417 (Iowa 1984).

c. County treasurer. The county treasurer may make an omitted assessment within two years from the date the tax list which should have contained the assessment should have been delivered to the county treasurer. For example, for the 1999 assessment year, the tax list is to be delivered to the county treasurer on or before June 30, 2000. Thus, the county treasurer may make an omitted assessment for the 1999 assessment year at any time on or before June 30, 2002. The county treasurer may make an omitted assessment of a building even if taxes levied against the land upon which the building is located have been paid or legally discharged. See *Okland v. Bilyeu*, 359 N.W.2d 412, 417 (Iowa 1984). The county treasurer may not make an omitted assessment if the omitted property is no longer owned by the person who owned the property on January 1 of the year the original assessment should have been made.

d. Director of revenue. The director of revenue may make an omitted assessment of any property assessable by the director at any time within two years from the date the assessment should have been made.

This rule is intended to implement Iowa Code chapter 440 and sections 443.6 through 443.15 as amended by 1999 Iowa Acts, chapter 174.

701—71.26(441) Assessor compliance. The assessor shall determine the value of real property in accordance with rules adopted by the department of revenue and in accordance with forms and guidelines contained in the Iowa Real Property Appraisal Manual prepared by the department. The assessor may use an alternative manual to value property if it is a unique type of property not covered in the manual prepared by the department.

If the department finds that an assessor is not in compliance with the rules of the department relating to valuation of property or has disregarded the forms and guidelines contained in the real property appraisal manual, the department shall notify the assessor and each member of the conference board for that assessing jurisdiction. The notice shall be mailed by restricted certified mail and shall specify the areas of noncompliance and the steps necessary to achieve compliance. The notice shall also inform the assessor and conference board that if compliance is not achieved, a penalty may be imposed.

The conference board shall respond to the department within 30 days of receipt of the notice of noncompliance. The conference board may respond to the notice by asserting that the assessor is in compliance with the rules, guidelines, and forms of the department or by informing the department that the conference board intends to submit a plan of action to achieve compliance. If the conference board responds to the notification by asserting that the assessor is in compliance, a hearing before the director of revenue shall be held on the matter within 60 days of receipt of the notice of noncompliance. If it is agreed that the assessor is not in compliance, the conference board shall submit a plan of action within 60 days of receipt of the notice of noncompliance.

The plan shall contain a time frame under which compliance shall be achieved, which shall be no later than January 1 of the following assessment year. The plan of action shall contain the signature of the assessor and of the chairperson of the conference board. The department shall review the plan to determine whether the plan is sufficient to achieve compliance. Within 30 days of receipt of the plan, the department shall notify the assessor and the chairperson of the conference board that it has accepted the plan or that it is necessary to submit an amended plan of action.

By January 1 of the assessment year following the calendar year in which the plan was submitted to the department, the conference board shall submit a report to the department verifying that the plan of action was followed and compliance has been achieved. The department may conduct a field inspection to ensure that the assessor is in compliance. By January 31, the department shall notify the assessor and the conference board, by restricted certified mail, either that compliance has been achieved or

that the assessor remains in noncompliance. If the department determines that the assessor remains in noncompliance, the department shall take steps to withhold up to 5 percent of the reimbursement payment authorized in Iowa Code section 425.1 until the director of revenue determines that the assessor is in compliance.

If the conference board disputes the determination of the department, the chairperson of the conference board may appeal the determination to the state board of tax review.

This rule is intended to implement Iowa Code Supplement section 441.21.

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721—21.1(47) Emergency election procedures. The state commissioner of elections may exercise emergency powers over any election being held in a district in which either a natural or other disaster or extremely inclement weather has occurred. The state commissioner may also exercise emergency powers during an armed conflict involving United States armed forces, or mobilization of those forces, or if an election contest court finds that there were errors in the conduct of an election making it impossible to determine the result.

21.1(1) Definitions.

“*Commissioner*” means the county commissioner of elections.

“*Election contest court*” means any of the courts specified in Iowa Code sections 57.1, 58.4, 61.1, 62.1 and 376.10.

“*Extremely inclement weather*” means a natural occurrence, such as a rainstorm, windstorm, ice storm, blizzard, tornado or other weather conditions, which makes travel extremely dangerous or which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

“*Natural disaster*” means a natural occurrence, such as a fire, flood, blizzard, earthquake, tornado, windstorm, ice storm, or other events, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

“*Other disaster*” means an occurrence caused by machines or people, such as fire, hazardous substance or nuclear power plant accident or incident, which threatens the public peace, health and safety of the people or which damages and destroys public and private property.

“*State commissioner*” means the state commissioner of elections.

21.1(2) Notice of natural or other disaster or extremely inclement weather. The county commissioner of elections, or the commissioner’s designee, may notify the state commissioner of elections that due to a natural or other disaster or extremely inclement weather an election cannot safely be conducted in the time or place for which the election is scheduled to be held. If the commissioner or the commissioner’s designee is unable to transmit notice of the hazardous conditions, the notice may be given by any elected county official. Verification of the commissioner’s agreement with the severity of the conditions and the danger to the election process shall be transmitted to the state commissioner as soon as possible. Notice may be given by telephone or by facsimile machine, but a signed notice shall also be delivered to the state commissioner.

21.1(3) Declaration of emergency due to natural or other disaster or extremely inclement weather. After receiving notice of hazardous conditions, the state commissioner of elections, or the state commissioner’s designee, may declare that an emergency exists in the affected precinct or precincts. A copy of the declaration of the emergency shall be provided to the commissioner.

21.1(4) Emergency modifications to conduct of elections. When the state commissioner of elections has declared that an emergency exists due to a natural or other disaster or to extremely inclement weather, the county commissioner of elections, or the commissioner’s designee, shall consult with the state commissioner to develop a plan to conduct the election under the emergency conditions. All modifications to the usual method for conducting elections shall be approved in advance by the state commissioner unless prior approval is impossible to obtain.

Modifications may be made to the method for conducting the election including relocation of the polling place, postponement of the hour of opening the polls, postponement of the date of the election if no candidates for federal offices are on the ballot, reduction in the number of precinct election officials in nonpartisan elections, or other reasonable and prudent modifications that will permit the election to be conducted.

21.1(5) *Relocation of polling place.* The substitute polling place shall be as close as possible to the usual polling place and shall be within the same precinct if possible. Preference shall be given to buildings which are accessible to the elderly and disabled. Buildings supported by taxation shall be made available without charge by the authorities responsible for their administration. If it is necessary, more than one precinct may be located in the same room.

A notice of the location of the substitute polling place shall be posted on the door of the former polling place not later than one hour before the scheduled time for opening the polls or as soon as possible. If it is unsafe or impossible to post the sign on the door of the former polling place, the notice shall be posted in some other visible place at or near the site of the former polling place. If time permits, notice of the relocation of the polling place shall be published in the same newspaper in which notice of election was published, otherwise notice of relocation may be published in any newspaper of general circulation in the political subdivision which will appear on or before election day. The commissioner shall inform all broadcast media and print news organizations serving the jurisdiction of the modifications.

21.1(6) *Postponement of election.* An election, other than an election at which a federal office appears on the ballot, may be postponed until the following Tuesday. If the election involves more than one precinct, the postponement must include all precincts within the political subdivision. If the election is postponed, ballots shall not be reprinted to reflect the modification in the election date. The date of the close of voter preregistration by mail for the election shall not be extended. Precinct election registers prepared for the original election date may be used or reprinted at the commissioner's discretion.

On the day that the postponed election is actually held, all election day procedures must be repeated.

21.1(7) *Absentee voting in postponed elections.* Absentee ballots shall be delivered to voters pursuant to Iowa Code section 53.22 until the date the election is actually held. Absentee ballots shall be accepted at the commissioner's office until the hour the polls close on the date the election is held. Absentee ballots which are postmarked no later than the day before the election is actually held shall be accepted if received no later than the time prescribed by the Iowa Code for the usual conduct of the election. The time shall be calculated from the date on which the election is held, not the date for which the election was originally scheduled. However, if absentee ballots have been tabulated before the election is postponed, the absentee ballots shall be sealed in an envelope by the absentee and special voters precinct board and stored securely until the date the election is actually held. The sealed envelopes shall be opened by the absentee and special voters precinct board on the date the election is actually held, counters on the tabulating equipment (if any) shall be reset to zero, and all absentee ballots tabulated on the original election date shall be retabulated.

21.1(8) *Absentee and special voters precinct board in postponed elections.* The absentee and special voters precinct board shall meet to consider provisional ballots at the times specified in Iowa Code sections 50.22 and 52.23, calculated from the date the election is held. No absentee ballots shall be counted until the date the election is held.

21.1(9) *Canvass of votes in postponed elections.* The canvass of votes shall also be rescheduled for one week after the originally scheduled canvass date.

21.1(10) *Postponements made on election day.* If the emergency is declared while the polls are open and the decision is made to postpone the election, each precinct polling place in the political subdivision shall be notified to close its doors and to halt all voting immediately. People present in the polling place who are waiting to vote shall not be given ballots. People who have received and marked their ballots shall deposit them in the ballot box; unmarked ballots may be returned to the precinct election officials.

The precinct election officials shall seal all ballots which were cast before the declaration of the emergency in secure containers. The containers shall be clearly marked as ballots from the postponed election. If it is safe to do so, the ballot containers, election register, and other election supplies shall be transported to the commissioner's office. The ballots shall be stored in a secure place. If it is unsafe to travel to the commissioner's office, the chairperson of the precinct election board shall see that the ballots and the election register are securely stored until it is safe to return them to the commissioner. If no contest is pending six months after the canvass for the election is completed, the unopened, sealed ballot containers shall be destroyed.

If automatic tabulating equipment is used, the automatic tabulating equipment shall be closed and sealed without printing the results. Before the date the election is held, the automatic tabulating equipment shall be reset to zero. Documents showing the progress of the count, if any, shall be sealed in an envelope and stored. No one shall reveal the progress of the count. After six months, the sealed envelope containing the vote totals shall be destroyed if no contest is pending.

21.1(11) *Records kept.* The state commissioner of elections shall maintain records of each emergency declaration. The records of emergency declarations for federal elections shall be kept for 22 months, and records for all other elections shall be kept for six months following the election. The records shall include the following information:

- a. The county in which the emergency occurred.
- b. The date and time the emergency declaration was requested.
- c. The name and title of the person making the request.
- d. Name and date of the election affected.
- e. The jurisdiction for which the election is to be conducted (school, city, county, or other).
- f. The number of precincts in the jurisdiction.
- g. The number of precincts affected by the emergency.
- h. The nature of the emergency, i.e., natural or other disaster, or extremely inclement weather.
- i. The date or dates of the occurrence of the natural or other disaster or extremely inclement weather.
- j. Conditions affecting the conduct of the election.
- k. Whether the polling places may safely be opened on time.
- l. Action taken: such as moving the polling place, change voting system, postpone election until the following Tuesday.
- m. Method to be used to inform the public of changes made in the election procedure.
- n. The signature of the state commissioner or the state commissioner's designee who was responsible for declaring the emergency.

21.1(12) *Federal elections.*

a. If an emergency occurs that will adversely affect the conduct of an election at which candidates for federal office will appear on the ballot, the election shall not be postponed or delayed. Emergency measures shall be limited to relocation of polling places, modification of the method of voting, reduction of the number of precinct election officials at a precinct and other modifications of prescribed election procedures which will enable the election to be conducted on the date and during the hours required by law.

The primary election held in June of even-numbered years and the general election held in November of even-numbered years shall not be postponed. Special elections called by the governor pursuant to Iowa Code section 69.14 shall not be postponed unless no federal office appears on the ballot.

b. If a federal or state court order extends the time established for closing the polls pursuant to Iowa Code section 49.73, any person who votes after the statutory hour for closing the polls shall vote only by casting a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballots cast after the statutory hour for closing the polls shall be sealed in a separate envelope from provisional ballots cast during the statutory polling hours. The absentee and special voters precinct board shall tabulate and report the results of the two sets of provisional ballots separately.

21.1(13) *Military emergencies.* A voter who is entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces," may return an absentee ballot via electronic transmission only if the voter is located in an area designated by the U.S. Department of Defense to be an imminent danger pay area. Procedures for the return of absentee ballots by electronic transmission are described in subrule 21.320(4).

21.1(14) *Election contest emergency.* If an election contest court finds that there were errors in the conduct of an election which make it impossible to determine the result of the election, the contest court shall notify the state commissioner of elections of its finding. The state commissioner shall order a repeat

election to be held. The repeat election date shall be set by the state commissioner. The repeat election shall be conducted under the state commissioner's supervision.

The repeat election shall be held at the earliest possible time, but it shall not be held earlier than 14 days after the date the election was set aside. Voter registration, publication, equipment testing and other applicable deadlines shall be calculated from the date of the repeat election.

The repeat election shall be conducted under the same procedures required for the election that was set aside, except that all known errors in preparation and procedure shall be corrected. The nominations from the initial election shall be used in the repeat election unless the contest court specifically rejects the initial nomination process in its findings. Precinct election officials for the repeat election may be replaced at the discretion of the auditor.

The following materials prepared for the original election shall be used or reconstructed for the repeat election:

Ballots (showing the date of repeat election). This may be stamped on ballots printed for the original election.

Notice of election (showing the date of repeat election).

This rule is intended to implement Iowa Code section 47.1.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.2(47) Electronic submission of absentee ballot applications and affidavits of candidacy. Absentee ballot applications and affidavits of candidacy may be submitted electronically using either fax or E-mail.

21.2(1) *Electronic copies of absentee ballot applications and affidavits of candidacy accepted for filing.* Assuming that all other legal requirements are met, absentee ballot applications and affidavits of candidacy required by Iowa Code chapters 43, 44, 45, 161A, 260C, 277, 376 and 420 may be submitted electronically by either fax or E-mail if presented to the appropriate filing officer as an exact copy of the original and if the submission is in compliance with subrule 21.2(2).

21.2(2) *Original absentee ballot applications.* The original absentee ballot application submitted electronically shall also be mailed to the commissioner. The envelope bearing the original absentee ballot application shall be postmarked not later than the Friday before the election. This subrule shall not apply to documents submitted electronically by UOCAVA voters pursuant to rule 721—21.320(53).

a. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the original absentee ballot application filed electronically is not received in the mail by the time the polls close on election day.

b. The voter's absentee ballot shall be rejected by the absentee and special voters precinct board if the postmark on the envelope containing the original absentee ballot application is later than the Friday before the election.

21.2(3) *Original affidavits of candidacy.* The original copy of an affidavit of candidacy submitted electronically shall also be filed with the appropriate commissioner. The envelope bearing the original affidavit (if any) shall be postmarked not later than the last day to file the document.

a. The filing shall be void if the original affidavit of candidacy filed electronically is not received within seven days after the filing deadline for the original affidavit of candidacy.

b. The filing shall be void if the postmark on the envelope containing the original affidavit of candidacy is later than the filing deadline.

c. If an affidavit of candidacy filing is voided because the original affidavit of candidacy submitted by facsimile machine was postmarked too late or arrives too late, the person who filed the document shall be notified immediately in writing.

This rule is intended to implement Iowa Code sections 43.11, 43.19, 43.54, 43.67, 43.78, 44.3, 45.3, 45.4, 46.20, 47.1, and 47.2; sections 53.2, 53.8, 53.17, 53.22, 53.25, and 53.40 as amended by 2009 Iowa Acts, House File 475; sections 53.45, 61.3, 161A.5, and 277.4; sections 260C.15 and 376.4 as amended by 2009 Iowa Acts, House File 475; and sections 376.11 and 420.130.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.3(49,48A) Voter identification documents.

21.3(1) *Identification documents for persons other than election day registrants.* Unless the person is registering to vote at the polls on election day, precinct election officials shall accept the identification documents listed in Iowa Code section 48A.8 from any person who is asked or required to present identification pursuant to Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

21.3(2) *Identification for election day registrants.*

a. A person who applies to register to vote on election day shall provide proof of identity and residence pursuant to Iowa Code section 48A.7A in the precinct where the person is applying to register and vote.

b. Any registered voter who attests for another person registering to vote at the polls on election day shall be a registered voter of the same precinct. The registered voter may be a precinct election official or a pollwatcher, but may not attest for more than one person applying to register at the same election.

21.3(3) *Current and valid identification.*

a. “Current and valid” or “identification,” for the purposes of this rule, means identification that meets the following criteria:

(1) The expiration date on the identification has not passed. An identification is still valid on the expiration date. An Iowa nonoperator’s identification that shows “none” as the expiration date shall be considered current and valid.

(2) The identification has not been revoked or suspended.

b. A current and valid identification may include a former address.

21.3(4) *Identification not provided.* A person who has been requested to provide identification and does not provide it shall vote only by provisional ballot pursuant to Iowa Code section 49.81. However, a person who is registering to vote on election day pursuant to Iowa Code section 48A.7A may establish identity and residency in the precinct by written oath of a person who is registered to vote in the precinct.

This rule is intended to implement Iowa Code section 48A.7A and section 49.77 as amended by 2009 Iowa Acts, House File 475, and P.L. 107-252, Section 303.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.4(49) Changes of address at the polls. An Iowa voter who has moved from one precinct to another in the county where the person is registered to vote may report a change of address at the polls on election day.

21.4(1) To qualify to vote in the election being held that day, the voter shall:

a. Go to the polling place for the precinct where the voter lives on election day.

b. Complete a registration form showing the person’s current address in the precinct.

c. Present proof of identity as required by subrule 21.3(1).

21.4(2) The officials shall require a person who is reporting a change of address at the polls to cast a provisional ballot if the person’s registration in the county cannot be confirmed. Registration may be confirmed by:

a. Telephoning the office of the county commissioner of elections, or

b. Reviewing a printed list of all registered voters who are qualified to vote in the county for the election being held that day, or

c. Researching the county’s voter registration records using a computer.

21.4(3) In precincts where the voter’s declaration of eligibility is included in the election register pursuant to rule 721—21.5(49) and Iowa Code section 49.77, the commissioner shall provide to each precinct one of the two following methods for recording changes of address:

a. The voter shall be given both an eligibility declaration and a voter registration form. The eligibility declaration may be printed on the same piece of paper as the voter registration form.

b. The commissioner shall provide blank lines on the election register for the precinct election officials to record the voter’s name, address, and, if provided, telephone number, and, in primary

elections, political party affiliation. The voter shall sign the election register next to the printed information. The voter shall also complete a voter registration form showing the voter's current address.

This rule is intended to implement Iowa Code section 49.77 as amended by 2009 Iowa Acts, House File 475.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.5(49) Eligibility declarations in the election register. To compensate for the absence of a separate declaration of eligibility form, the commissioner shall provide to each precinct a voter roster with space for each person who appears at the precinct to vote to print the following information: first and last name, address, and, at the voter's option, telephone number, and, in primary elections, political party affiliation.

The roster forms shall include the name and date of the election and the name of the precinct, and may be provided on paper that makes carbonless copies. If a multicopy form is used, the commissioner shall retain the original copy of the voter roster with other records of the election.

This rule is intended to implement Iowa Code section 49.77.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.6(43,50) Turnout reports. Rescinded IAB 6/2/10, effective 7/1/10.

721—21.7(48A) Election day registration. In addition to complying with the identification provisions in rule 721—21.3(49,48A), precinct election officials shall comply with the following requirements:

21.7(1) Precinct election officials shall inspect the identification documents presented by election day registrants to verify the following:

- a. The photograph shows the person who is registering to vote.
- b. The name on the identification document is the same as the name of the applicant.
- c. The address on the identification document is in the precinct where the person is registering to vote.

21.7(2) Precinct election officials shall verify that each person who attempts to attest to the identity and residence of a person who is registering to vote on election day is a registered voter in the precinct and has not attested for any other voter in the election. The officials shall note in the election register that the person has attested for an election day registrant.

21.7(3) Precinct election officials shall permit any person who is in line to vote at the time the polls close to register and vote on election day if the person otherwise meets all of the election day registration requirements.

21.7(4) In precincts where an electronic program is not used to check the name of an election day registrant against the statewide list of felons who have had their right to vote revoked, precinct election officials shall provide each election day registrant with a "Notice to Election Day Registrants" prepared by the state commissioner before allowing the voter to register and vote on election day. The "Notice to Election Day Registrants" prepared by the state commissioner will be posted on the state commissioner's Web site.

This rule is intended to implement 2007 Iowa Acts, House File 653.

[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8777B, IAB 6/2/10, effective 5/7/10]

721—21.8(48A) Notice to election day registrant. The commissioner shall send to each person who registers to vote on election day, pursuant to Iowa Code section 48A.7A, an acknowledgment of the registration by nonforwardable mail. If the postal service returns the acknowledgment as undeliverable, the commissioner shall send a notice to the voter by forwardable mail. The notice shall be substantially in the form titled "Notice to Election Day Registrant" posted on the state commissioner's Web site.

This rule is intended to implement Iowa Code sections 48A.7A and 48A.26A.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.9(49) "Vote here" signs.

1. Size. The signs shall be no smaller than 16 inches by 24 inches.

2. Exceptions. If a driveway leads away from the entrance to the voting area, or if the driveway is located in such a way that posting a “vote here” sign at the driveway entrance would not help potential voters find the voting area, no “vote here” sign shall be posted at the entrance to that driveway.

This rule is intended to implement Iowa Code section 49.21.

721—21.10(43) Application for status as a political party. A political organization which is not currently qualified as a political party may file an application for determination of political party status with the state commissioner of elections. The application may be filed after the completion of the executive council’s canvass of votes for the general election, but not later than one year after the date of the election at which the organization’s candidate for President of the United States or governor received at least 2 percent of the vote.

21.10(1) Application form. The application shall be substantially in the form titled “Application for Political Party Status” posted on the state commissioner’s Web site.

21.10(2) Response. If the political organization meets the requirements established in Iowa Code section 43.2, the commissioner shall declare that the organization has qualified as a political party, effective 21 days after the application is approved. If the organization does not meet the requirements, the state commissioner shall immediately notify the applicant in writing of the reason for the rejection of the application.

21.10(3) Disqualification of political party. If at the close of nominations for the general election a political party has not nominated a candidate for the office of President of the United States, or for governor, as the case may be, the political party shall be disqualified immediately.

If the candidate of a political party for President of the United States or for governor, as the case may be, does not receive 2 percent of the votes cast for that office at a general election, the political party shall be disqualified. The effective date of the disqualification shall be the date of the completion of the state canvass of votes.

When a political party is disqualified, the state commissioner shall immediately notify the chairperson or central committee of the disqualified political party.

21.10(4) Notice of qualification and disqualification of political parties. The state commissioner of elections shall immediately notify the state registrar of voters, the voter registration commission, and the county commissioners of elections when a political party is qualified or disqualified. The notice shall include the name of the political party and the date upon which change in political party status becomes effective.

The state commissioner of elections shall also publish notice of the qualification or disqualification of a political party in a newspaper of general circulation in each congressional district. The publication shall be made within 30 days of the approval of an application for qualification or within 30 days of the effective date of a disqualification.

This rule is intended to implement Iowa Code sections 43.2 and 47.1.
[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.11(44) Nonparty political organizations—nominations by petition. Rescinded IAB 9/10/97, effective 10/15/97.

721—21.12 to 21.19 Reserved.

721—21.20(62) Election contest costs. In determining the amount of the bond for election contests, the commissioner shall consider the following aspects of the cost of the election contest proceedings:

1. Fees as provided in Iowa Code section 62.22.
2. Fees for judges as provided in Iowa Code section 62.23.
3. The cost of making an official record of the proceedings.

721—21.21(62) Limitations. The amount of the bond shall not include costs not directly related to the contest court proceedings. Specifically, the amount of the bond shall not be intended to replace any

potential lost income to the county caused by the delay in implementing the decision of the voters at the election being contested.

Rules 721—21.20(62) and 721—21.21(62) are intended to implement Iowa Code sections 62.6, 62.22, 62.23, and 62.24.

721—21.22 to 21.24 Reserved.

721—21.25(50) Administrative recounts. When the commissioner suspects that voting equipment used in the election malfunctioned or that programming errors may have affected the outcome of the election, the commissioner may request an administrative recount after the day of the election but not later than three days after the canvass of votes. The request shall be made in writing to the board of supervisors explaining the nature of the problem and listing the precincts to be recounted and which offices and questions shall be included in the administrative recount. The board of supervisors shall respond as soon as possible after receipt of the commissioner's request.

The recount shall be conducted by members of the absentee and special voters precinct board following the provisions of Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, Iowa Code section 50.49 and 721—Chapter 26. The commissioner may use different memory cards for the recount and shall retain the information on the memory cards used in the election pursuant to 721—subrule 22.51(13). The commissioner may also use different election definition files if the commissioner believes the original election definition files were flawed. If the commissioner uses different election definition files for the recount, the commissioner shall also retain the election definition files for the election as required by 721—subrule 22.51(14).

This rule is intended to implement Iowa Code section 50.48 as amended by 2009 Iowa Acts, House File 475, and Iowa Code section 50.49.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.26 to 21.29 Reserved.

721—21.30(49) Inclusion of annexed territory in city reprecincting and redistricting plans. If a city has annexed territory after January 1 of a year ending in zero and before the completion of the redrawing of precinct and ward boundaries during a year ending in one, the city shall include the annexed land in precincts drawn pursuant to Iowa Code sections 49.3 and 49.5.

21.30(1) When the city council draws precinct and ward boundaries, if any, the city shall use the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(2) When the board of supervisors, or the temporary county redistricting commission, draws precinct and county supervisor district boundaries, if any, it shall subtract from the population of the adjacent unincorporated area the population of the annexed territory as certified by the city to the state treasurer pursuant to Iowa Code section 312.3(4).

21.30(3) The use of population figures for reprecincting or redistricting shall not affect the official population of the city or the county. Only the U.S. Bureau of the Census may adjust the official population figures, by corrections or by conducting special censuses. See Iowa Code section 9F.6.

This rule is intended to implement Iowa Code sections 49.3 and 49.5.

721—21.31 to 21.49 Reserved.

721—21.50(49) Polling place accessibility standards.

21.50(1) Inspection required. Before any building may be designated for use as a polling place, the county commissioner of elections or the commissioner's designee shall inspect the building to determine whether it is accessible to persons with disabilities.

21.50(2) Frequency of inspection. Polling places that have been inspected using the Polling Place Accessibility Survey Form prescribed in subrule 21.50(4) shall be reinspected if structural changes are made to the building or if the location of the polling place inside the building is changed.

21.50(3) Review of accessibility. Not less than 90 days before each primary election, the commissioner shall determine whether each polling place needs to be reinspected.

21.50(4) Standards for determining polling place accessibility. The survey form available on the state commissioner's Web site titled "Polling Place Accessibility Survey" shall be used to evaluate polling places for accessibility to persons with disabilities.

The term "off-street parking" used in the polling place accessibility survey means parking places in lots separated from the street and includes angle parking along the street if the accessible route from the parking place to the polling place is entirely out of the path of traffic. Parking arrangements that require either the driver or passengers of the vehicle to go into the traveled part of the street are not accessible.

An access aisle at street level that is at least 60 inches wide and the same length as each accessible parking space shall be provided. An accessible public sidewalk curb ramp shall connect the access aisle to the continuous passage to the polling place. At least one parking place shall be van-accessible with a 96-inch access aisle connected to the continuous passage to the polling place by an accessible public sidewalk curb ramp. Two accessible parking spaces may share a common access aisle.

21.50(5) Temporary waiver of accessibility requirements. Notwithstanding the waiver provisions of 721—Chapter 10, if the county commissioner is unable to provide an accessible polling place for any precinct, the commissioner shall apply for a temporary waiver of accessibility requirements pursuant to this subrule. Applications shall be filed with the secretary of state not later than 60 days before the date of any scheduled election. If a waiver is granted, it shall be valid for two years from the date of approval by the secretary of state.

a. Each application shall include the following documents:

(1) Application for Temporary Waiver of Accessibility Requirements.

(2) A copy of the Polling Place Accessibility Survey Form for the polling place to be used.

(3) A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for the precinct.

b. If an accessible place becomes available at least 30 days before an election, the commissioner shall change polling places and shall notify the secretary of state. The notice shall include a copy of the Polling Place Accessibility Survey Form for the new polling place.

21.50(6) Emergency waivers. During the 60 days preceding an election, if a polling place becomes unavailable for use due to fire, flood, or changes made to the building, or for other reasons, the commissioner must apply for an emergency waiver of accessibility requirements in order to move the polling place to an inaccessible building. Emergency waiver applications must be filed with the secretary of state as soon as possible before election day. To apply for an emergency waiver, the commissioner shall send the following documents:

a. Application for Temporary Waiver of Accessibility Requirements.

b. A copy of the Polling Place Accessibility Survey Form for the polling place selected.

c. A copy of the Polling Place Accessibility Survey Form for any other buildings that were surveyed and rejected as possible polling place sites for this precinct (if any).

21.50(7) Application form. The form posted on the state commissioner's Web site titled "Temporary Waiver of Accessibility Requirements" shall be used to apply for a temporary waiver of accessibility requirements.

21.50(8) Evaluation of waivers. When the secretary of state receives waiver applications, the applications shall be reviewed carefully. A response shall be sent to the commissioner within one week by E-mail or by fax to notify the commissioner when the waiver request was received and whether additional information is needed.

21.50(9) Granting waivers. If the secretary of state determines from the documents filed with the waiver request that conditions justify the use of a polling place that does not meet accessibility standards, the secretary of state shall grant the waiver of accessibility requirements. If the secretary of state determines from the documents filed with the waiver request that all potential polling places have been surveyed and no accessible place is available, and the available building cannot be made temporarily accessible, the waiver shall be granted.

21.50(10) Notice required. Each notice of election published pursuant to Iowa Code section 49.53 shall clearly describe which polling places are inaccessible. The notice shall include a description of the services available to persons with disabilities who live in precincts with inaccessible polling places. The notice shall be in substantially the following form:

Any voter who is physically unable to enter a polling place has the right to vote in the voter's vehicle. For further information, please contact the county auditor's office at the telephone or TTY number or E-mail address listed below:

Telephone: _____ TTY: _____ E-mail address: _____

21.50(11) Denial of waiver requests. The secretary of state shall review each waiver request. The secretary of state shall consider the totality of the circumstances as shown by the information on the waiver request, information contained in previous applications for waivers for the same precinct and for other precincts in the county, and other relevant available information. The waiver request may be denied if it appears that the commissioner has not made a good-faith effort to find an accessible polling place. If the waiver request is denied, the secretary of state shall notify the commissioner in writing of the reason for denying the request.

This rule is intended to implement Iowa Code section 49.21.
[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.51 to 21.74 Reserved.

721—21.75(49) Voting centers for certain elections. The commissioner may establish voting centers for the regular city election, city primary election, city runoff election, regular school election, and special elections.

21.75(1) Definition.

"Voting center" means a location established by the commissioner for the purpose of providing ballots to all registered voters who are qualified to vote in a particular jurisdiction for a regular city election, city primary election, city runoff election, regular school election, or special election.

21.75(2) Minimum requirements.

a. Establishment. One or more voting centers may be established in lieu of precinct polling places for the elections at which the use of voting centers is permitted. Regular polling place sites that are accessible to people with disabilities may be used as voting centers for any election at which the use of voting centers is permitted. Other suitable locations may also be used.

b. Location of voting centers. If voting centers are established for an election, at least one voting center must be located within the boundaries of the political subdivision for which the election is being conducted. At the commissioner's discretion, additional vote centers may be established as long as the voting center is located within the boundaries of the political subdivision for which the election is being conducted.

c. Accessibility. A voting center is subject to the requirements of Iowa Code section 49.21 relating to accessibility to persons who are elderly and persons with disabilities and relating to the posting of signs.

21.75(3) Hours. Voting center hours shall be the same as permitted for an election pursuant to Iowa Code section 49.73.

21.75(4) Publications. The location of each voting center shall be published in the notice of election by the commissioner in the same manner as the location of polling places is required to be published. The notice of election shall also include a description of the voting center in substantially the following form:

For the _____ election to be held on [date], voting centers will be available. Any registered voter of [jurisdiction name] may vote at any of the following places in this election:

[List addresses of voting centers.]

21.75(5) Posting notices at regular polling places on election day. If voting centers are established in lieu of regular polling places for an election, the commissioner shall post a notice of voting center

locations, not later than the hour at which the polls open on the day of the election, on each door to the usual polling place in the precinct. The notice shall remain posted until the polls have closed.

21.75(6) *I-Voters use prohibited.* The commissioner shall not provide direct access from voting centers to the I-Voters system on election day.

21.75(7) *Determining ballot rotations.* For the purposes of determining ballot rotations pursuant to Iowa Code section 49.31 in an election for which the commissioner has established voting centers, the commissioner may use either precincts established pursuant to Iowa Code sections 49.3 to 49.5 or consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph “a.” If the commissioner uses consolidated precincts established pursuant to Iowa Code section 49.11, subsection 3, paragraph “a,” the commissioner shall use the same consolidated precincts used in the last regularly scheduled election conducted for the political subdivision in which voting centers were not used.

21.75(8) *Operation of voting centers.*

a. Election registers and voter lists. Each voting center shall have an election register containing the names, addresses and voter statuses of all registered voters who are eligible to vote in that election. The election register may be a paper list or may be available on computers in an electronic format, rather than as an interactive connection to I-Voters.

b. Election day registration at voting centers. A person who needs to register to vote may register and vote at a voting center provided that the person has appropriate identification and is a resident of the jurisdiction served by the voting center.

c. Voters reporting address changes at voting centers. Any person who is already registered in the county and updates the person's voter registration address at a voting center shall show identification listed in Iowa Code section 48A.8. Persons unable to provide requested identification shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

d. Ballots. Each voting center shall have all ballot styles necessary to provide a ballot to any voter who is eligible to vote in the election for the jurisdiction served by the voting center.

e. Precinct election officials. Voting centers shall be administered by a minimum of three precinct election officials selected pursuant to Iowa Code sections 49.12 to 49.16. These officials shall be trained before each election and shall have specific instructions regarding the differences between voting centers and polling places.

f. Ballot boxes used with optical scan voting equipment at voting centers. The commissioner may instruct two precinct election officials not of the same political party to open the ballot box periodically throughout election day to ensure the ballots are stacking evenly in the ballot box to prevent a voting equipment malfunction. The precinct election officials charged with inspecting the ballot box shall ensure the ballot box is locked and secured at all times. As an alternative to this procedure, the commissioner may supply any voting center with additional ballot boxes and the precinct election officials may move the optical scan voting equipment to a new ballot box if necessary. All ballot boxes containing voted ballots shall be locked and secured by the precinct election officials at all times.

21.75(9) *Postelection review of voter participation.*

a. Within 45 days after the election, the commissioner shall review the signed declarations of eligibility or the signed election registers from each voting center, and if any person is found to have voted in more than one voting center in the election, the commissioner shall immediately notify the county attorney.

b. The notice to the county attorney shall include a copy of the person's voter registration record and copies of the declarations of eligibility signed by the voter. The notice shall also include a reference to Iowa Code sections 39A.2(2) and 49.11(3)“b.”

This rule is intended to implement Iowa Code sections 49.9 and 49.11.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.76 to 21.199 Reserved.

DIVISION II
BALLOT PREPARATION**721—21.200(49) Constitutional amendments and public measures.**

21.200(1) The order of placement on the ballot for constitutional amendments and statewide public measures to be voted upon at a single election shall be determined by the state commissioner, and a number shall be assigned to each constitutional amendment or statewide public measure by the state commissioner.

a. The number assigned by the state commissioner to each constitutional amendment or statewide public measure to appear on the ballot for a single election shall be printed on the ballot immediately preceding and above the words “Shall the following amendment to the Constitution (or public measure) be adopted?” or the words “Shall there be a Convention to revise the Constitution, and propose amendment or amendments to same?”

b. The number assigned by the state commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

c. Even if only one constitutional amendment or statewide public measure is to appear on a ballot to be voted upon at a single election, an identifying number shall be assigned by the state commissioner and shall be printed on the ballot in the prescribed manner.

21.200(2) The order of placement on the ballot for each local public measure to be voted upon at a single election shall be determined by the commissioner, and a letter shall be assigned to each local public measure by the commissioner.

a. The letter assigned by the commissioner shall be printed on the ballot at least 1/8 of an inch high in the designated place.

b. Even if only one public measure is to appear on a ballot to be voted upon at a single election, an identifying letter shall be assigned by the commissioner and shall be printed on the ballot in the prescribed manner.

21.200(3) The words describing proposed constitutional amendments and statewide public measures when they appear on the ballot shall be determined by the state commissioner. The state commissioner shall select the words describing the proposed constitutional amendments and statewide public measures in the following manner:

a. Not less than 150 days prior to the election at which a proposed constitutional amendment or statewide public measure is to be voted on by the voters, the state commissioner shall prepare a proposed description to be used on the ballots in administrative rule form and shall file the proposed rules with the administrative rules coordinator for publication in the Iowa Administrative Bulletin.

b. The rules shall provide that written comments regarding the proposed description will be accepted by the state commissioner for a period of time not less than 20 days after the date of publication in the Iowa Administrative Bulletin.

c. The state commissioner shall review any written comments which have been timely received and make any changes deemed to be warranted in the description to be printed on the ballots.

This rule is intended to implement Iowa Code sections 47.1 and 49.44.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.201(44) Competing nominations by nonparty political organizations.

21.201(1) *Nominations by convention and by petitions.* If one or more nomination petitions are received from nonparty political organization candidates for an office for which the same organization has also nominated one candidate by convention, the candidate nominated by convention shall be considered the nominee of the organization. The names of the other candidates shall appear on the ballot as candidates “nominated by petition,” and those candidates shall be notified in writing not later than seven days after the close of the filing period.

21.201(2) *Multiple nomination petitions.* If nomination petitions are received from more than one candidate from the same nonparty political organization for the same office and the organization has not nominated a candidate for the office by convention, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and

placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates shall appear on the ballot as candidates “nominated by petition.” A copy of the written record of the result of the drawing shall be kept with the nomination petition of each affected candidate, and each candidate shall be sent a copy for the candidate’s records not later than seven days after the close of the filing period.

21.201(3) *Multiple nomination certificates.* If more than one nomination certificate is received for the same office from groups with the same nonparty political organization name, the name of each of these candidates shall be written on a separate piece of paper, all of which shall be as nearly uniform in size and material as possible and placed in a receptacle so that the names cannot be seen. On the next working day following the close of the nomination period, all affected candidates shall be notified of the time and place of the drawing. The candidates shall be invited to attend or to send a representative. In the presence of witnesses, the state commissioner of elections or the county commissioner, as appropriate, or a designee of the state or county commissioner, shall publicly draw one of the names; and that person shall be declared to be the nominee of the nonparty political organization. The names of the other candidates, including any candidate who filed nomination petitions, shall appear on the ballot as candidates “nominated by petition.” A copy of the written record of the result of the drawing shall be kept with the nomination certificate of each affected candidate, and each candidate shall be sent a copy for the candidate’s records not later than seven days after the close of the filing period.

This rule is intended to implement Iowa Code section 44.17.

721—21.202(43,52) Form of primary election ballot. All primary election ballots shall meet the following formatting requirements:

21.202(1) *Required information.* In addition to other requirements listed in the Iowa Code, primary election ballots shall also include the following information:

- a. The name of the election.
- b. The name of the party, which shall be printed at the top of the ballot in at least 24-point type.
- c. The name of the county.
- d. Instructions for how to mark the ballot.

21.202(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.202(3) *Office titles and order of offices.* Each office printed on the ballot shall be preceded by an office title. The order of offices on the primary election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles on the primary election ballot shall be listed as follows:

- (1) U.S. Senator (if any).
- (2) U.S. Representative, District ____.
- (3) Governor.
- (4) Secretary of State.
- (5) Auditor of State.
- (6) Treasurer of State.
- (7) Secretary of Agriculture.
- (8) Attorney General.
- (9) State Senator, district ____ (if any).
- (10) State Representative, District ____.
- (11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ____).
- (12) Treasurer.
- (13) Recorder.
- (14) County Attorney.

b. In presidential election years, the order of office titles on the primary election ballot shall be listed as follows:

- (1) U.S. Senator (if any).
- (2) U.S. Representative, District ____.
- (3) State Senator, District ____ (if any).
- (4) State Representative, District ____.
- (5) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ____).
- (6) Auditor.
- (7) Sheriff.

c. If an office is printed on the primary election ballot followed by the words “To Fill Vacancy,” that office shall be listed after the other offices under the appropriate heading. If the office followed by the words “To Fill Vacancy” is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.202(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: “Vote for no more than ____.” The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election.

21.202(5) *Write-in vote targets.* After the candidates’ names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.202(4). Under each write-in line, the following words shall be printed: “Write-in vote, if any.”

21.202(6) *Font size.* Candidates’ names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.202(7) *Two-sided ballots.* If a primary election ballot must be printed on two sides, the words “Turn the ballot over” shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 43.31 [2009 Iowa Acts, House File 475, section 6].

[ARC 8698B, IAB 4/21/10, effective 6/15/10; ARC 9049B, IAB 9/8/10, effective 8/16/10]

721—21.203(49,52) Form of general election ballot. All general election ballots shall meet the following formatting requirements:

21.203(1) *Required information.* In addition to other requirements listed in the Iowa Code, general election ballots shall also include the following information:

- a. The name of the election.
- b. The name of the county.
- c. Instructions for how to mark the ballot, including instructions for voting on judicial retentions and constitutional amendments or public measures and instructions for straight-party voting.
- d. Ballot location of the judges’ names and any constitutional amendment(s).

21.203(2) *Headings and lines.* Rescinded IAB 9/8/10, effective 8/16/10.

21.203(3) *Office titles, order of offices and public measures.* Each office printed on the ballot shall be preceded by an office title. The order of offices and public measures listed on the general election ballot shall be as follows:

a. In gubernatorial election years, the order of office titles and public measures on the general election ballot shall be listed as follows:

- (1) U.S. Senator (if any).
- (2) U.S. Representative, District ____.
- (3) Governor and Lt. Governor.
- (4) Secretary of State.
- (5) Auditor of State.
- (6) Treasurer of State.
- (7) Secretary of Agriculture.
- (8) Attorney General.
- (9) State Senator, District ____ (if any).

- (10) State Representative, District ____.
 - (11) Board of Supervisors (if plan II or plan III, then Board of Supervisors, District ____).
 - (12) Treasurer.
 - (13) Recorder.
 - (14) County Attorney.
 - (15) Township Trustee (if any).
 - (16) Township Clerk (if any).
 - (17) County Public Hospital Trustee (if any).
 - (18) Soil and Water Conservation District Commissioner.
 - (19) County Agricultural Extension Council Member.
 - (20) Other nonpartisan offices (if any).
 - (21) Supreme Court Justice (if any).
 - (22) Court of Appeals Judge (if any).
 - (23) District Court Judge (if any).
 - (24) District Court Associate Judge (if any).
 - (25) Associate Juvenile Judge (if any).
 - (26) Associate Probate Judge (if any).
 - (27) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:
 1. Constitutional Amendment (if any).
 2. State Public Measure (if any).
 3. County Public Measure (if any).
 4. City Public Measure (if any).
- b. In presidential election years, the order of office titles on the general election ballot shall be listed as follows:
- (1) President and Vice President.
 - (2) U.S. Senator (if any).
 - (3) U.S. Representative, District ____.
 - (4) State Senator, District ____ (if any).
 - (5) State Representative, District ____.
 - (6) Board of Supervisors (if plan II or plan III, then Board of Supervisors, district ____).
 - (7) Auditor.
 - (8) Sheriff.
 - (9) Township Trustee (if any).
 - (10) Township Clerk (if any).
 - (11) County Public Hospital Trustee (if any).
 - (12) Soil and Water Conservation District Commissioner.
 - (13) County Agricultural Extension Council Member.
 - (14) Other nonpartisan offices (if any).
 - (15) Supreme Court Justice (if any).
 - (16) Court of Appeals Judge (if any).
 - (17) District Court Judge (if any).
 - (18) District Court Associate Judge (if any).
 - (19) Associate Juvenile Judge (if any).
 - (20) Associate Probate Judge (if any).
 - (21) Public Measures (if any). Under the public measures heading, measures shall be listed in the following order:
 1. Constitutional Amendment (if any).
 2. State Public Measure (if any).
 3. County Public Measure (if any).
 4. City Public Measure (if any).

c. If an office is printed on the general election ballot followed by the words “To Fill Vacancy,” that office shall be listed after the other offices under the appropriate heading. If the office followed by the words “To Fill Vacancy” is the board of supervisors, that office shall appear after the other board of supervisors office(s).

21.203(4) *Vote for number.* Under each office title, the number of choices a voter may make in the race shall be printed in the following form: “Vote for no more than ____”. The number of choices the voter may make for each race is the number of individuals to be elected to the office at the general election. Under the “President and Vice President” office title, “Vote for no more than one team” shall be printed on the ballot. Under the “Governor and Lt. Governor” office title, “Vote for no more than one team” shall be printed on the ballot.

21.203(5) *Write-in vote targets.* After the candidates’ names for each office (if any), a target shall be placed next to a line for voters to write in a nominee for the office. The number of write-in targets and lines printed under each office shall match the vote for number referenced in subrule 21.203(4). Under each write-in line, the following words shall be printed: “Write-in vote, if any”. For the offices of President and Vice President, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: “Write-in vote for President, if any” and “Write-in vote for Vice President, if any”. For the offices of governor and lieutenant governor, there shall be one write-in target printed to the left of two write-in lines. Under the write-in lines, the commissioner shall print the following: “Write-in vote for Governor, if any” and “Write-in vote for Lt. Governor, if any”.

21.203(6) *Font size.* Candidates’ names shall be printed in upper and lower case letters, and the font size shall be no less than 10-point type.

21.203(7) *Two-sided ballots.* If a general election ballot must be printed on two sides, the words “Turn the ballot over” shall be printed on both sides of the ballot, at the bottom.

This rule is intended to implement 2009 Iowa Code Supplement section 49.57A [2009 Iowa Acts, House File 475, section 32].

[ARC 8698B, IAB 4/21/10, effective 6/15/10; ARC 9049B, IAB 9/8/10, effective 8/16/10]

721—21.204 to 21.299 Reserved.

DIVISION III
ABSENTEE VOTING

721—21.300(53) Satellite absentee voting stations.

21.300(1) *Establishment of stations.* Satellite absentee voting stations may be established by the county commissioner of elections or by a petition of eligible electors of the jurisdiction conducting the election.

a. *Satellite absentee voting stations established by the county commissioner.* The county commissioner of elections may designate locations in the county for satellite absentee voting stations. Satellite absentee voting stations established by the commissioner shall be accessible to elderly and disabled voters. Satellite absentee voting stations must also be established so as to provide for voting in secret and ballot security.

b. *Satellite absentee voting stations established after receipt of a valid petition.* A petition requesting a satellite absentee voting station shall be substantially in the form titled “Petition Requesting Satellite Absentee Voting Station” available on the state commissioner’s Web site. If the commissioner receives a petition requesting a satellite absentee voting station on or before the petition deadline set forth in Iowa Code section 53.11, the commissioner shall determine the validity of the petition within 24 hours. A petition requesting a satellite absentee voting station is valid if it contains signatures of not less than 100 eligible electors of the jurisdiction conducting the election. Electors signing the petition must include their signature, house number, street, and date the petition was signed. Signatures on lines not containing all of the required information shall not be counted. The heading on each page of the petition shall include the satellite location requested and the election name or date for which the location is requested. Signatures on petition pages without the required heading shall not be counted.

c. Mandatory rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations shall be rejected within four days of the commissioner's receipt of the petition if:

- (1) The site requested is not accessible to elderly and disabled voters,
- (2) The site requested has other physical limitations that make it impossible to meet the requirements for ballot security and secret voting, or
- (3) The owner of the site refuses permission to locate the satellite absentee voting station at the site requested on the petition.

d. Discretionary rejection of certain satellite absentee voting stations. Otherwise valid petitions for satellite absentee voting stations may be rejected within four days of the commissioner's receipt of the petition if:

- (1) A petition is received requesting satellite voting for a city runoff election and a special election is scheduled to be held between the regular city election and a city runoff election.
- (2) The owner of the site demands payment for its use.

e. Provision of ballots. Only ballots from the county in which the site is located may be provided at the satellite absentee voting station. Ballots must be provided for the precinct in which the satellite absentee voting station is located; however, it is not necessary to provide ballots from all of the precincts in the political subdivision for which the election is being conducted.

21.300(2) Notice provided. Notice shall be published at least seven days before the opening of any satellite absentee voting station. If more than one satellite absentee voting station will be provided, a single publication may be used to notify the public of their availability. If it is not possible to publish the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be published as soon as possible.

A notice shall also be posted at each satellite absentee voting station at least seven days before the opening of the satellite absentee voting station. The notice shall remain posted as long as the satellite absentee voting station is scheduled for service. If it is not possible to post the notice at least seven days before the station opens due to the receipt of a petition, the notice shall be posted as soon as possible.

Both the published and posted notices shall include the following information:

- a.* The name and date of the election for which ballots will be available.
- b.* The location(s) of the satellite absentee voting station(s).
- c.* The dates and times that the station(s) will be open.
- d.* The precincts for which ballots will be available.
- e.* An announcement that voter registration forms will be available for new registrations in the county and that changes in the registration records of people who are currently registered within the county may be made at any time.

If the satellite absentee voting station is located in a building with more than one public entrance, brief notices of the location of the satellite absentee voting station shall be posted on building directories, bulletin boards, or doors. These notices shall be posted no later than the time the station opens and shall be removed immediately after the satellite absentee voting station has ceased operation for an election.

21.300(3) Staff. Satellite absentee voting station workers may be selected from among the staff members of the commissioner's office, from the election board panel drawn up pursuant to Iowa Code sections 49.15 and 49.16, or a combination of these two sources. Compensation of workers selected from the election board panel shall be at the rate provided in Iowa Code section 49.20.

At least three people shall be assigned to work at each satellite absentee voting station; more workers may be added at the commissioner's discretion. All workers must be registered voters of the county, and for primary and general elections the workers must be registered with a political party; however, workers not affiliated with any party may be assigned to work at a satellite absentee voting station as long as not more than one-third of the workers assigned to a particular satellite absentee voting station are not affiliated with a political party. For all elections, no more than a simple majority of the workers shall be members of the same political party.

People who are prohibited from working at the polls pursuant to Iowa Code section 49.16 may not work at satellite absentee voting stations.

21.300(4) *Oath required.* Before the first day of service at a satellite absentee voting station, each worker shall take an oath substantially in the form titled “Election Official/Clerk Oath” available on the state commissioner’s Web site. The oath must be taken before each election.

21.300(5) *Suggested supplies for each satellite absentee voting station.* A list of supplies suggested for each satellite absentee voting station is available on the state commissioner’s Web site.

21.300(6) *Ballot transport and storage.* At the commissioner’s discretion the ballots may be transported between the commissioner’s office and the satellite absentee voting station by the workers who will be on duty that day, or by two people of different political parties who have been designated as couriers by the commissioner. It is not necessary for the same people to transport the ballots in both directions.

If the ballots are transported by the satellite absentee voting station workers, two workers who are members of different political parties and the ballots must travel together in the same vehicle.

Ballots may be stored at the satellite absentee voting station during hours when the station is closed only if they are kept in a locked cabinet or container. The cabinet must be located in a room which is kept locked when not in use. Voted absentee ballots must be delivered to the commissioner’s office at least once each week.

21.300(7) *Ballot receipts.* Satellite absentee voting station workers shall sign receipts for the ballots taken to the satellite absentee voting site. The receipt shall be substantially in the form titled “Satellite Absentee Voting Station Ballot Record and Receipt” available on the state commissioner’s Web site. A copy of the ballot record and receipt shall be retained in the commissioner’s office. The original shall be sent with the ballots to the satellite absentee voting station.

21.300(8) *Arrangement of the satellite absentee voting station.* Protection of the security of the ballots (both voted and unvoted) and the secrecy of each person’s vote shall be considered in the arranging of the satellite absentee voting station.

a. Security. The satellite absentee voting station shall be arranged so that ballots are protected against removal from the station by unauthorized persons.

b. Voting area. Voting booths without curtains shall be placed so that passersby and other voters may not walk directly behind a person using the booth. At least one voting booth must be accessible to the disabled. The booth must be designed to accommodate a person seated in a chair or wheelchair. A chair must be provided for voters who wish to sit down while voting or waiting in line.

c. Campaign signs and electioneering. No signs supporting or opposing any candidate or question on the ballot shall be posted on the premises of or within 300 feet of any outside door of any building affording access to a satellite absentee voting station during the hours when absentee ballots are available at the satellite absentee voting station. No electioneering shall be allowed within the sight or hearing of voters while they are at the satellite absentee voting station.

21.300(9) *Operation of the satellite absentee voting station.* At all times the satellite absentee voting station shall have at least two workers present to preserve the security of the ballots, both voted and unvoted.

21.300(10) *Voter registration at the satellite absentee voting station.* Each satellite absentee voting station shall provide forms necessary to register voters, including the oaths necessary to process voters registering pursuant to Iowa Code section 48A.7A, and to record changes in voter registration records. Workers shall also be provided with a method of verifying whether people applying for absentee ballots are registered voters.

The commissioner may provide a list of registered voters in the precincts served by the station. The list may be on paper or contained in a computerized data file. As an alternative, the commissioner may provide a computer connection with the commissioner’s office.

21.300(11) *Procedure for issuing absentee ballot.* The instructions for absentee voting are available on the state commissioner’s Web site and shall be provided to satellite absentee voting station workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner’s Web site.

21.300(12) *Closing a station.* The instructions for closing a satellite absentee voting station are available on the state commissioner’s Web site and shall be provided to satellite absentee voting station

workers unless the commissioner prepares instructions containing substantially the same information as the instructions available on the state commissioner's Web site.

21.300(13) *Use of I-Voters at satellite absentee voting stations.* Any county commissioner who wants to use the I-Voters statewide voter registration database at a satellite absentee voting station shall:

a. Complete an application to use I-Voters at a satellite absentee voting station. A separate application shall be completed for each satellite absentee voting station. The application is available on the state commissioner's Web site. The application shall be submitted at least seven days before the opening of the satellite absentee voting station. If it is not possible to submit an application at least seven days before the station opens due to the receipt of a petition, the application shall be submitted as soon as possible. The application will be considered by the state commissioner as soon as practicable after it is received. The state commissioner reserves the right to reject an application for any reason or to limit the number of users at any satellite absentee voting station.

b. Use a cellular telephone service or a wired Internet connection to connect to the Internet from the satellite absentee voting station. If the county uses a wired Internet connection, the commissioner shall use either a regular or a wireless router between the wired Internet connection and the county's computers. Connection to a facility's wireless network is not permitted.

c. Configure any wireless routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

- (1) A minimum 10-character password must be assigned to the router administration screens.
- (2) WPA (AES) security for wireless connections with a minimum 10-character password must be used.

(3) Remote management of the router must be prohibited.

(4) Universal Plug & Play must be turned off.

(5) Port forwarding on the router must not be disabled.

(6) Unauthorized connections shall be prohibited, including smartphones, personal digital assistants (PDAs) and laptops.

d. Configure any wired routers to be used between the facility's wired Internet connection and the county's laptop computers as follows:

(1) Remote management of the router must be prohibited.

(2) Universal Plug & Play must be turned off.

(3) Port forwarding on the router must not be disabled.

(4) Unauthorized connections shall be prohibited, including smartphones, PDAs and laptops.

(5) Administrator passwords for the routers must be changed from the default passwords, and standard county password policies shall be followed.

e. Laptops used at a satellite absentee voting station shall be configured as follows:

(1) The hard drives must be encrypted.

(2) The operating system must be fully supported by the operating system vendor.

(3) The operating system must be fully patched.

(4) Antivirus software and anti-spyware must be installed and up to date.

(5) A full antivirus and anti-spyware scan must be done during the week before a laptop is used at a satellite absentee voting station and at least once a week thereafter while the laptop is being used at satellite absentee voting stations.

(6) The administrator password must be changed from the default password.

(7) Guest user accounts must be disabled or renamed.

(8) File/print sharing must be turned off, and remote access must be disabled.

(9) Bluetooth must be turned off.

(10) The Windows firewall must be turned on.

f. Laptops connected to I-Voters at a satellite absentee voting station shall never be left unattended.

g. Laptops connected to I-Voters at a satellite absentee voting station shall not have any USB memory sticks or CDs/DVDs inserted in the computer after the virus scan is conducted pursuant to subrule 21.300(13), paragraph "e."

h. Laptops connected to I-Voters at a satellite absentee voting station shall not be used to visit any other Web sites.

i. No software applications, other than I-Voters, shall be used while the I-Voters application is in use at a satellite absentee voting station.

This rule is intended to implement Iowa Code section 53.11.
[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 9139B, IAB 10/6/10, effective 9/16/10]

721—21.301(53) Absentee ballot requests from voters whose registration records are “inactive.”

21.301(1) *In person.* Absentee voters whose registration records are “inactive” and who appear in person to vote, either at the office of the commissioner or at a satellite absentee voting station, shall be assigned a status of “active” after requesting an absentee ballot.

21.301(2) *By mail.* When a request for an absentee ballot is received by mail from a voter whose registration record has been made “inactive” pursuant to Iowa Code section 48A.29, the commissioner shall update the voter’s residential address to the address listed on the absentee ballot request if requested by the voter and assign the voter a status of “active.”

21.301(3) *Absentee ballots received from a voter subsequently assigned “inactive” status.* The commissioner shall set aside the absentee ballot of a voter whose status is changed to “inactive” pursuant to Iowa Code section 48A.26, subsection 6, after the voter has submitted the voter's ballot. The commissioner shall notify the voter, pursuant to Iowa Code section 53.31, informing the voter that the absentee ballot may be counted if the voter personally delivers or mails a copy of the voter’s identification as set forth in Iowa Code section 48A.8 to the commissioner’s office before the absentee and special voters precinct board convenes to count absentee ballots, or reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22. If the commissioner does not receive a copy of the voter’s identification before the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the absentee and special voters precinct board shall reject the absentee ballot.

This rule is intended to implement Iowa Code section 48A.29 and sections 48A.26, 48A.37 and 53.25 as amended by 2009 Iowa Acts, House File 475.
[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.302(48A) In-person absentee registration. After the close of voter registration for an election, a person who appears in person to apply for and vote an absentee ballot may register to vote if the person provides proof of identity and residence in the precinct in which the voter intends to vote using identification that meets the requirements set forth in Iowa Code section 48A.7A. The voter must also complete an oath of person registering on election day. If the voter does not have appropriate identification, the voter may establish identity and residence using the attestation procedure in Iowa Code section 48A.7A, subsection 1, paragraph “c.” Otherwise, the person may cast only a provisional ballot pursuant to Iowa Code section 49.81. Provisional ballot envelopes shall be used.

This rule is intended to implement Iowa Code section 48A.7A.
[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.303(53) Mailing absentee ballots. The commissioner shall mail the following materials to each person who has requested an absentee ballot:

1. Ballot. The ballot that corresponds to the voter’s residence, as indicated by the address on the absentee ballot application.
2. Public measure text. The full text of any public measures that are summarized on the ballot, but not printed in full.
3. Secrecy envelope. Secrecy envelope, if the ballot cannot be folded to cover all of the voting ovals, as required by Iowa Code section 53.8(1).
4. Affidavit envelope. The affidavit envelope, which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner’s records.
5. Return carrier envelope. The return carrier envelope, which shall be addressed to the commissioner’s office and bear appropriate return postage or a postal permit guaranteeing that the

commissioner will pay the return postage and which shall be marked with the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records.

6. Delivery envelope. The delivery envelope, which shall be addressed to the voter and bear the I-Voters-assigned sequence number used to identify the absentee request in the commissioner's records. All other materials shall be enclosed in the delivery envelope.

7. Instructions. Absentee voting instructions, which shall be in substantially the form prescribed by the state commissioner of elections.

8. Receipt. The receipt form required by 2007 Iowa Acts, Senate File 601, section 227, which may be printed on the instructions required by numbered paragraph "7" above.

This rule is intended to implement Iowa Code sections 53.8 and 53.17 as amended by 2009 Iowa Acts, House File 475.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.304(53) Absentee ballot requests from voters whose registration records are "pending." A voter who requests an absentee ballot and is assigned a status of "pending" must provide identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475.

21.304(1) In-person applicants. In-person applicants for absentee ballots assigned a status of "pending" must show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, before casting a ballot. If an in-person applicant provides identification as required by Iowa Code section 48A.8 when casting an absentee ballot in person, the commissioner shall assign the voter's registration record a status of "active" and provide the voter with an absentee ballot. Voters who are unable to provide identification as required by Iowa Code section 48A.8 shall be offered a provisional ballot pursuant to Iowa Code section 49.81.

21.304(2) By-mail applicants. By-mail applicants for absentee ballots assigned a status of "pending" must either come to the commissioner's office and show identification pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, or mail a photocopy of identification pursuant to Iowa Code section 48A.8 before the voter's absentee ballot can be counted by the absentee and special voters precinct board. The commissioner shall mail the voter a notice informing the voter of the requirement to provide one of the identification documents listed in Iowa Code section 48A.8 before the voter's absentee ballot can be considered for counting by the absentee and special voters precinct board. If a by-mail applicant provides identification as required by Iowa Code section 48A.8, the commissioner shall assign the voter's registration record a status of "active."

21.304(3) By-mail absentee voters assigned a status of "pending" who do not provide identification prior to election day. The ballot of a by-mail absentee voter assigned a status of "pending" who has not shown identification in person at the commissioner's office or provided a photocopy of identification by mail pursuant to Iowa Code section 48A.8 as amended by 2009 Iowa Acts, House File 475, shall be challenged by a member of the absentee and special voters precinct board on election day pursuant to Iowa Code section 53.31. The absentee and special voters precinct board shall immediately mail notice of the challenge to the voter. The notice shall include the deadline for the voter to provide identification pursuant to Iowa Code section 48A.8. If the voter provides identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's ballot shall be considered for counting by the absentee and special voters precinct board. If the voter does not provide identification pursuant to Iowa Code section 48A.8 prior to the time the absentee and special voters precinct board reconvenes to consider challenged absentee ballots pursuant to Iowa Code section 50.22, the voter's absentee ballot shall be rejected by the absentee and special voters precinct board. The voter shall be notified of the reason for rejection pursuant to Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475.

This rule is intended to implement Iowa Code section 53.31 and sections 48A.8 and 53.25 as amended by 2009 Iowa Acts, House File 475.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.305(53) Confirming commissioner's receipt of an absentee ballot on election day. If a voter's name is on the absentee list prepared pursuant to Iowa Code sections 49.72 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196, and the voter appears at the polling place to vote on election day, the precinct election officials may contact the commissioner's office to confirm whether the commissioner has received the voter's absentee ballot. If the precinct election officials are able to confirm either that the commissioner has not received the voter's absentee ballot or that the voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the precinct election officials shall permit the voter to cast a regular ballot at the polling place.

After confirming that a voter's absentee ballot has not been received or that a voter's absentee ballot has been received but cannot be counted due to a defective or incomplete affidavit, the commissioner shall mark the voter's absentee ballot as "Void" in the statewide voter registration system. The commissioner shall enter "Voted at polls" in the comment box that appears when the ballot is marked as "Void."

If a voter's absentee ballot is returned to the commissioner's office after being marked as "Void" pursuant to this rule, the absentee ballot shall be rejected by the absentee and special voters precinct board pursuant to Iowa Code section 53.25 because the voter cast a ballot in person at the polling place.

This rule is intended to implement Iowa Code sections 49.72, 49.81 and 53.19 as amended by 2010 Iowa Acts, Senate File 2196.

[ARC 8779B, IAB 6/2/10, effective 7/1/10]

721—21.306 to 21.319 Reserved.

721—21.320(53) Absentee voting by UOCAVA voters. This rule applies only to absentee voting by persons who are entitled to vote by absentee ballot under the federal Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(1) Definitions. The following definitions apply to this rule:

"Armed forces," as used in this rule, is defined in Iowa Code section 53.37(3).

"FPCA" means the federal postcard absentee ballot application and voter registration form authorized for use in Iowa by Iowa Code section 53.38.

"UOCAVA voter" means any person who is entitled to vote by absentee ballot under the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) and Iowa Code chapter 53, division II, "Absent Voting by Armed Forces."

21.320(2) Requests for absentee ballots. All requests for absentee ballots shall be made in writing. Additional requirements for requesting absentee ballots and for processing the requests are set forth below.

a. Forms. UOCAVA voters may use the following official forms to request absentee ballots:

- (1) A federal postcard absentee ballot application and voter registration form (FPCA).
- (2) A state of Iowa official absentee ballot request form.
- (3) For general elections only, a proxy absentee ballot application prescribed by the state commissioner of elections and submitted pursuant to Iowa Code Supplement section 53.40(1) "b."

b. Form not required. UOCAVA voters may request absentee ballots in writing without using an official form. The written request shall be honored if it includes all of the following information about the voter:

- (1) Name.
- (2) Age or date of birth.
- (3) Iowa residence, including street address (if any) and city.
- (4) Address to which the ballot shall be sent.
- (5) Township of residence, if applicable.
- (6) County of residence.
- (7) Party affiliation, if the request is for a ballot for a primary election.
- (8) Signature of voter.

(9) Statement explaining why the voter is eligible to receive ballots under the provisions of Iowa Code chapter 53, division II. For example, "I am a U.S. citizen living in France."

c. Methods for transmitting absentee ballot requests. UOCAVA voters may transmit absentee ballot requests by any of the following methods:

- (1) Mail.
- (2) Personal delivery by the voter or a person designated by the voter.
- (3) Facsimile machine.
- (4) Scanned application form or letter transmitted by E-mail. Requests by E-mail that do not include either an image of the physical signature or a digital signature shall not be accepted.

d. Original request not needed. If the request is sent by E-mail or by fax, it is not necessary for the UOCAVA voter to send to the commissioner the original copy of the FPCA or other official form or written request for an absentee ballot.

e. Multiple requests from the same person. Before the ballot is ready to mail, if the commissioner receives more than one request for an absentee ballot for a particular election (or series of elections) by or on behalf of a UOCAVA voter, the last request received shall be the one honored. However, if one of the requests is for a general election ballot and is made using the proxy absentee ballot application process permitted by Iowa Code Supplement section 53.40(1)"b," the request received from the voter shall be the one honored, not the proxy request.

f. Subsequent request after ballot has been sent. Not more than one ballot shall be transmitted by the commissioner to any UOCAVA voter for a particular election unless, after the ballot has been mailed or transmitted electronically pursuant to rule 721—21.320(53), the voter reports a change in the address, E-mail address or fax number to which the ballot should be sent. The commissioner shall void the original absentee ballot request and include a comment in the voter's registration record, noting the I-Voters-sequence number of the original ballot and noting that a replacement ballot was sent to an updated address. If the original ballot is returned voted, it shall be counted only if the replacement ballot does not arrive before the deadline for receiving absentee ballots set forth in Iowa Code section 53.17.

g. Requests for absentee ballots through the end of the calendar year. 2009 Iowa Code Supplement section 53.40 as amended by 2010 Iowa Acts, Senate File 2194, permits UOCAVA voters to request the commissioner to send absentee ballots for all elections as permitted by state law. In response to an absentee ballot request in which the UOCAVA voter requests ballots for all elections, the commissioner shall send the applicant a ballot for each election held after the request is received through the end of the calendar year in which the request is received. If the applicant does not request ballots for all elections or does not specify which elections the request is for, the commissioner shall send the applicant a ballot only for federal elections through the end of the calendar year in which the request is received.

(1) When an absentee ballot for a UOCAVA voter is returned as undeliverable by the United States Postal Service or an E-mail server or a fax cannot be transmitted to the number provided by the voter, the commissioner shall do the following:

1. Verify that the commissioner's office sent the absentee ballot to the address, E-mail address or fax number requested by the UOCAVA voter. If the absentee ballot was sent incorrectly, the commissioner shall correct the error and immediately transmit a new absentee ballot.

2. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall E-mail the voter if the commissioner has an E-mail address on file to inform the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address if the voter wishes to continue to receive absentee ballots.

3. If the absentee ballot was sent to the correct mailing address, E-mail address or fax number, the commissioner shall also attempt to contact the voter by sending a forwardable notice to both the voter's residential address and the voter's absentee mailing address informing the voter that the voter's ballot was returned undeliverable, and the commissioner must be provided with a new FPCA containing a new mailing address, E-mail address or fax number if the voter wishes to continue to receive absentee ballots.

4. If the absentee ballot was mailed, E-mailed or sent to the correct address or fax number, the commissioner shall terminate the voter's current FPCA request and shall not send the voter any further ballots unless a new absentee ballot request is received from the voter.

(2) If the voter provides a new FPCA with a new mailing address, E-mail address or fax number before election day, the commissioner shall enter a new absentee request on the voter's registration record and transmit the ballot via the method requested by the voter. The voter may request that the commissioner transmit the ballot electronically pursuant to subrule 21.320(3).

21.320(3) *Electronic transmission of absentee ballots to UOCAVA voters.*

a. Electronic transmission of absentee ballots by facsimile machine or by E-mail is limited to UOCAVA voters who specifically ask for this service. A UOCAVA voter who asks for electronic transmission of an absentee ballot may request this service for all elections for which the person is qualified to vote or for specific elections either individually or for a specific period of time. The commissioner may employ FVAP's secure transmission program to facilitate electronic transmission of absentee ballots to UOCAVA voters.

b. Forms. The state commissioner shall provide the following forms and instructions for the electronic transmission of absentee ballots to UOCAVA voters:

- (1) Instructions to the county commissioners of elections for providing this service.
- (2) Instructions to the voter for marking and returning the ballot.
- (3) The affidavit envelope form, which can be printed by the voter on an envelope and used for the voter's declaration of eligibility and voter registration application, if necessary.

(4) The return envelope form, which can be printed by the voter on an envelope and used to return the ballot, postage paid through the FPO/APO postal service.

21.320(4) *Ballot return by electronic transmission.*

a. Electronic transmission of a voted absentee ballot from the voter to the commissioner is permitted only for UOCAVA voters who are in an area designated as an imminent danger pay area, as provided in subrule 21.1(13). In addition, the absentee ballot may be returned via electronic transmission only if the voter waives the right to a secret ballot. In addition to signing the affidavit required by Iowa Code section 53.13, the voter shall sign a statement in substantially the following form: "I understand that by returning this ballot by electronic transmission my voted ballot will not be secret. I hereby waive my right to a secret ballot."

b. When an absentee ballot is received via electronic transmission, the person receiving the transmission shall examine it to determine that all pages have been received and are legible. The person receiving an electronic transmission shall not reveal how the voter voted.

c. The absentee ballot shall be sealed in an envelope marked with the voter's name. The affidavit of the voter and the application for the ballot shall be attached to the envelope. These materials shall be stored with other returned absentee ballots.

This rule is intended to implement Iowa Code sections 53.40 and 53.46.
[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8777B, IAB 6/2/10, effective 5/7/10]

721—21.321 to 21.349 Reserved.

721—21.350(53) Absentee ballot processing for elections held following July 1, 2007. Rescinded IAB 9/26/07, effective 9/7/07.

721—21.351(53) Receiving absentee ballots. The commissioner shall carefully account for and protect all absentee ballots returned to the office.

21.351(1) *Note receipt.* The commissioner shall write or file-stamp on the return carrier envelope the date that the ballot arrived in the commissioner's office. The commissioner shall also record receipt of the ballot in I-Voters.

21.351(2) *Temporary storage.* If necessary, the commissioner shall immediately put the ballot into a secure container, such as a locked ballot box, until the ballots can be moved to the secure storage area.

21.351(3) *Secure area.* The commissioner shall deliver the ballots to a secure area where returned absentee ballots will be reviewed for completeness and defects.

[ARC 8779B, IAB 6/2/10, effective 7/1/10]

721—21.352(53) Review of returned affidavit envelopes.

21.352(1) *Personnel.* The commissioner may assign staff members to complete the review of returned affidavit envelopes. Only persons who have been trained for this responsibility shall be authorized to review affidavit envelopes.

21.352(2) *Affidavit envelopes reviewed.* The affidavit envelopes of all absentee ballots returned to the commissioner's office shall be reviewed, including those of ballots returned by the bipartisan team delivering absentee ballots to health care facilities, such as hospitals and nursing homes. If a reviewer finds that any absentee affidavits returned from any health care facility are incomplete or defective, the commissioner shall send the bipartisan delivery team back to assist voters as needed with completing affidavits or to deliver any replacement ballots.

21.352(3) *Instructions.* Each reviewer shall receive instructions in substantially the form prepared by the state commissioner of elections. The instructions shall provide basic security and procedural guidance and include a method for accounting for all returned absentee ballots. The prohibitions shall include:

- a. Leaving unsecured ballots unattended.
- b. Altering any information on any affidavit.
- c. Adding any information to any affidavit, except as specifically required to comply with the requirements of the law.
- d. Sealing any affidavit envelope found open.
- e. Discarding any return carrier envelopes, ballots, or affidavit envelopes returned by voters.

[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8779B, IAB 6/2/10, effective 7/1/10]

721—21.353(53) Opening the return carrier envelopes. The commissioner may direct a staff member to open the return carrier envelopes either manually or with an automatic letter opener, if one is available. Only a trained reviewer may remove the contents of the envelope.

721—21.354(53) Review process. A reviewer shall remove the contents from only one return carrier envelope at a time.

21.354(1) *Return carrier envelopes preserved.* The return carrier envelopes shall be stored in a manner that will facilitate their retrieval, if necessary. They shall be stored for 22 months for federal elections and 6 months for local elections.

21.354(2) *Examination of affidavit envelope.* The reviewer shall make sure that:

- a. The affidavit envelope is sealed, apparently with the ballot inside.
- b. The affidavit envelope has not been opened and resealed.
- c. The affidavit includes all of the following:
 - (1) A signature.
 - (2) For primary elections only, political party affiliation.

21.354(3) *No defects or incomplete information.* If the reviewer finds that the required information on the affidavit is complete and that there are no defects that would cause the absentee and special voters precinct board to reject the ballot, the reviewer shall put the affidavit envelope into a group of envelopes to be retained in the secure storage area with others that require no further attention until they are delivered to the absentee and special voters precinct board.

21.354(4) *Defective and incomplete affidavits.* The commissioner shall contact the voter if the reviewer finds any of the following flaws in the affidavit or affidavit envelope:

- a. The commissioner shall contact the voter immediately if the affidavit envelope is defective. An affidavit envelope is defective if:
 - (1) The absentee ballot is not enclosed in the affidavit envelope.
 - (2) The affidavit envelope is not sealed.
 - (3) The affidavit envelope has been opened and resealed.
 - (4) The voter submits a change of address in a new precinct after returning a voted absentee ballot.
- b. The commissioner shall contact the voter within 24 hours if the affidavit is incomplete. An incomplete affidavit lacks:

- (1) The signature of the voter.
- (2) For primary elections only, political party affiliation.

c. If an affidavit envelope has flaws that are included in both paragraphs “a” and “b,” the commissioner shall follow the process in paragraph “a.”

21.354(5) Defective and incomplete affidavits stored separately. The commissioner shall store the defective and incomplete affidavit envelopes separately from other returned absentee ballot affidavit envelopes.

a. Incomplete affidavit envelopes requiring voter correction must be available for retrieval when the voter comes to make corrections.

b. Defective affidavit envelopes must be attached to the replacement ballot (if any) for review by the absentee and special voters precinct board.

[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8779B, IAB 6/2/10, effective 7/1/10]

721—21.355(53) Notice to voter. When the commissioner finds an incomplete absentee ballot affidavit or finds a defective affidavit envelope, the commissioner shall notify the voter in writing and, if possible, by telephone and by E-mail. The commissioner shall keep a separate checklist for each voter showing the reasons for which the voter was contacted and the methods used to contact the voter.

21.355(1) Notice to voter—incomplete ballot affidavit. Within 24 hours after receipt of an absentee ballot with an incomplete affidavit, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include:

a. Explanation of missing required information (lack of signature or, for primary elections only, political party affiliation).

b. The voter’s options for correcting the affidavit as follows:

- (1) Completing the affidavit at the commissioner’s office by 5 p.m. the day before the election;
- (2) Requesting a replacement ballot pursuant to Iowa Code section 53.18; or
- (3) Voting at the polls on election day.

c. Address of commissioner’s office, business hours and contact information.

21.355(2) Notice to voter—defective ballot affidavit. Immediately after determining that an absentee ballot affidavit envelope is defective, the commissioner shall send a notice to the voter at the address where the voter is registered to vote, as well as to the address where the ballot was sent, if it is a different address. The notice shall include the following information:

a. Reason for defect.

b. The voter’s options for correcting the defect as follows:

- (1) Requesting a replacement ballot; or
- (2) Voting at the polls on election day.

c. Process for requesting a replacement ballot.

d. Address of commissioner’s office, business hours and contact information.

21.355(3) Telephone contact. If the voter has provided a telephone number, either on the absentee ballot application or on the voter’s registration record, the commissioner shall also attempt to contact the voter by telephone. The commissioner shall keep a written record of the telephone conversation. The written record shall include the following information:

a. Name of the person making the call.

b. Date and time of the call.

c. Whether the person making the call spoke to the voter.

21.355(4) E-mail contact. If the voter has provided an E-mail address, either on the absentee ballot application or on the voter’s registration record, the commissioner shall also attempt to contact the voter by E-mail. The E-mail message shall be the same message that was mailed to the voter. A copy of the E-mail message shall be attached to the checklist.

[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8779B, IAB 6/2/10, effective 7/1/10]

Rules 721—21.351(53) through 721—21.355(53) are intended to implement 2009 Iowa Code Supplement section 53.18 as amended by 2010 Iowa Acts, Senate file 2196, and section 53.25.

721—21.356 to 21.358 Reserved.

721—21.359(53) Processing absentee ballots before election day. The commissioner may only direct the absentee and special voters precinct board to open affidavit envelopes on the Monday before election day under the following circumstances:

For any election, only if the commissioner has provided secrecy envelopes (or folders) pursuant to subrule 21.359(1) and the commissioner determines removing secrecy envelopes from affidavit envelopes is necessary due to the quantity of voted absentee ballots received as set forth in Iowa Code section 53.23, subsection 3, paragraph “a.”

For general elections, if the commissioner convenes the absentee and special voters precinct board pursuant to Iowa Code section 53.23, subsection 3, paragraph “c,” to begin tabulation of absentee ballots.

21.359(1) The secrecy envelope shall completely cover the ballot. The envelope shall have the following message printed on it using at least 24-point type:

Secrecy Envelope

After you vote, put your ballot in here.

21.359(2) When the absentee and special voters precinct board convenes to begin processing absentee ballots, the board shall first review voters’ affidavits to determine which ballots will be accepted for counting and prepare the notices to those voters whose ballots have been rejected for the reasons set forth in 2009 Iowa Code Supplement section 53.25. Affidavit envelopes containing ballots that are rejected shall be stored in the manner prescribed by Iowa Code section 53.26. The applications submitted for rejected ballots shall be stored in a secure location for the time period required by Iowa Code section 50.19.

21.359(3) The affidavit envelopes containing ballots that have been accepted for counting by the absentee and special voters precinct board shall be stacked with the affidavits facing down. The envelopes shall be opened and the secrecy envelope containing the ballot shall be removed.

21.359(4) If a voter has not enclosed the ballot in a secrecy envelope and the ballot has not been folded in a manner that conceals all votes marked on the ballot, the officials shall put the ballot in a secrecy envelope without examining the ballot.

21.359(5) The following security procedures shall be followed:

a. The process shall be witnessed by observers appointed by the county chairperson of each of the political parties referred to in Iowa Code section 49.13, subsection 2. If, after receiving notice from the commissioner pursuant to Iowa Code section 53.23, subsection 3, paragraph “a,” either or both political parties fail to appoint an observer, the commissioner may continue with the proceedings.

b. No ballots shall be counted or examined before election day except as provided in Iowa Code section 53.23, subsection 3, paragraph “c,” as amended by 2009 Iowa Acts, House File 670, section 1.

c. When secrecy envelopes are removed from affidavit envelopes on the day before an election and not tabulated as permitted by Iowa Code section 53.23, subsection 3, paragraph “c,” as amended by 2009 Iowa Acts, House File 670, section 1, the number of secrecy envelopes shall be recorded before the ballots are stored and the number shall be verified before any ballots are removed from the secrecy envelopes on election day. The ballots may be bundled and sealed in groups of a specified number to make counting easier.

This rule is intended to implement Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.

[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8779B, IAB 6/2/10, effective 7/1/10]

721—21.360(53) Failure to affix postmark date. Rescinded IAB 4/20/11, effective 3/31/11.

721—21.361(53) Rejection of absentee ballot. The absentee and special voters precinct board shall reject absentee ballots without opening the affidavit envelope if any of the conditions cited in Iowa Code section 53.25 as amended by 2009 Iowa Acts, House File 475, exist.

21.361(1) An absentee ballot shall be rejected if the affidavit lacks the voter's signature.

21.361(2) An absentee ballot shall be rejected if the applicant is not a duly registered voter in the precinct in which the ballot is cast. "Precinct" means a precinct established pursuant to Iowa Code sections 49.3 through 49.5 or a consolidated precinct established by the commissioner pursuant to Iowa Code section 49.11, subsection 3, paragraph "a."

21.361(3) An absentee ballot shall be rejected if the affidavit envelope is open.

21.361(4) An absentee ballot shall be rejected if the affidavit envelope has been opened and resealed.

21.361(5) An absentee ballot shall be rejected if the affidavit envelope contains more than one ballot of any kind.

21.361(6) An absentee ballot shall be rejected if the voter has voted in person at the polls.

21.361(7) An absentee ballot shall be rejected if in primary elections the voter does not declare a party affiliation on the voter's affidavit.

This rule is intended to implement Iowa Code sections 49.9 and 53.14 and section 53.25 as amended by 2009 Iowa Acts, House File 475.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.362 to 21.369 Reserved.

721—21.370(53) Training for absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.371(53) Certificate. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.372(53) Frequency of training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.373(53) Registration of absentee ballot couriers. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.374(53) County commissioner's duties. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.375(53) Absentee ballot courier training. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.376(53) Receiving absentee ballots. Rescinded IAB 8/1/07, effective 7/1/07.

721—21.377 to 21.399 Reserved.

DIVISION IV
INSTRUCTIONS FOR SPECIFIC ELECTIONS

721—21.400(376) Signature requirements for certain cities. This rule applies to cities which have all of the following characteristics:

1. Nomination procedures under Iowa Code section 376.3 are used. (This includes cities with primary or runoff election provisions. It does not include cities with nominations under Iowa Code chapter 44 or 45.)

2. Some or all council members are voted upon by the electors of wards, rather than by the electors of the entire city.

3. Ward boundaries have been changed since the last regular city election at which the ward seat was on the ballot.

4. The number of wards has not changed.

Calculation of the number of signatures for ward seats shall use the vote totals from the wards as the wards were configured at the time of the last regular city election at which the ward seat was on the ballot.

This rule is intended to implement Iowa Code section 376.4.

721—21.401(376) Signature requirements in cities with primary or runoff election provisions. In cities using the provisions of Iowa Code section 376.4 for nomination of candidates and in which more than one council member was elected at-large at the last preceding regular city election, the number of signatures shall be calculated by the following formula:

V = the total number of votes cast for all candidates for council member at-large at the last regular city election;

E = the number of people to be elected at the last regular city election;

$$\frac{V}{E} \times .02 = \text{the number of signatures needed by each candidate in the next regular city election.}$$

This rule is intended to implement Iowa Code section 376.4.

721—21.402(372) Filing deadline for charter commission appointment petition. If a special election has been called by a city to present to the voters the question of adopting a different form of city government, receipt by the city council of a petition requesting appointment of a charter commission shall stay the special election if the petition is received no later than 5 p.m. on the Friday preceding the date of the special election.

This rule is intended to implement Iowa Code section 372.3.

721—21.403(81GA, HF2282) Special elections to fill vacancies in elective city offices for cities that may be required to conduct primary elections.

21.403(1) Notice to the commissioner. At least 60 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election.

a. If the commissioner finds no conflict with other previously scheduled elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

b. No special city elections to fill vacancies for cities that may be required to conduct primary elections shall be held with the general election, with the primary election, or with the annual school election. To do so would be contrary to the provisions of Iowa Code section 39.2.

21.403(2) Election calendar. The election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the fifty-third day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the fifty-third day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the fiftieth day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the fiftieth day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.404(81GA, HF2282) Special elections to fill vacancies in elective city offices for cities without primary election requirements. This rule applies to cities that have adopted by ordinance one of the following options: nominations under Iowa Code chapter 44 or chapter 45, or a runoff election requirement if no candidate in the special election receives a majority of the votes cast.

21.404(1) Notice to the commissioner. At least 32 days before the proposed date of the special election, the city council shall give written notice to the commissioner who will be responsible for conducting the special election. If the commissioner finds no conflict with other previously scheduled

elections, or with other limitations on the dates of special elections, the commissioner shall immediately notify the council that the date has been approved.

21.404(2) *Special elections to fill vacancies held in conjunction with the general election.* If the proposed date of the special election coincides with the date of the general election, the council shall give notice of the proposed date of the special city election not later than 76 days before the date of the general election. Candidates shall file nomination papers with the city clerk not later than 5 p.m. on the seventieth day before the general election. The city clerk shall deliver the nomination papers accepted by the clerk not later than 5 p.m. on the sixty-ninth day before the general election. Objection and withdrawal deadlines shall be 64 days before the general election, the same as the deadlines for candidates who file their nomination papers with the commissioner. Hearings on objections shall be held as soon as possible in order to facilitate printing of the general election ballot.

21.404(3) *Election calendar.* If the special election date is not the same as the date of the general election, the election calendar shall be adjusted as follows:

a. The deadline for candidates to file nomination papers with the city clerk shall be not later than 12 noon on the twenty-fifth day before the election.

b. The city clerk shall deliver all nomination papers accepted by the clerk to the county commissioner of elections not later than 5 p.m. on the twenty-fifth day before the election.

c. A candidate who has filed nomination papers for the special election may withdraw not later than 5 p.m. on the twenty-second day before the election.

d. A person who would have the right to vote for the office in question may file a written objection to the legal sufficiency of a candidate's nomination papers or to the qualifications of the candidate for this special election not later than 12 noon on the twenty-second day before the election.

e. The hearing on the objection must be held within 24 hours of receipt of the objection.

This rule is intended to implement Iowa Code section 372.13(2) as amended by 2006 Iowa Acts, House File 2282, section 2.

721—21.405 to 21.499 Reserved.

721—21.500(277) Signature requirements for school director candidates. The number of signatures required to be filed by candidates for the office of director in the regular school election shall be calculated from the number of registered voters in the district on May 1 of the year in which the election will be held. If May 1 falls on a day when the commissioner's office is closed for business, the commissioner shall use the number of registered voters in the district on the next day that the commissioner's office is open for business to determine the number of required signatures. Candidates who are seeking election in districts with election plans as specified in Iowa Code section 275.12(2) "b" and "c," where the candidate must reside in a specific director district, but is voted upon by all of the electors of the school district, shall be required to file a number of signatures calculated from the number of registered voters in the whole school district. Candidates who will be voted upon only by the electors of a director district shall be required to file a number of signatures calculated from the number of registered voters in the director district in which the candidate resides and seeks to represent.

If a special election is to be held to fill a vacancy on the school board, the number of registered voters on the date the commissioner receives notice of the special election shall be used to calculate the number of signatures required for the special election.

This rule is intended to implement Iowa Code sections 277.4 and 279.7.
[ARC 9466B, IAB 4/20/11, effective 3/31/11]

721—21.501 to 21.599 Reserved.

721—21.600(43) Primary election signatures—plan three supervisor candidates. The minimum number of signatures needed by candidates for the office of county supervisor elected under plan three, where candidates are voted upon only by the voters of the supervisor district, shall be determined by one of the two following methods.

21.600(1) If there were 5,000 or more votes cast in the supervisor district for a political party's candidate for governor or for president of the United States, the minimum number of signatures needed is 100.

21.600(2) If there were less than 5,000 votes cast in the supervisor district for a political party's candidate for governor or for president of the United States, the minimum number of signatures is determined by using one of the following formulas:

Democratic candidate's signature requirement: $([AD \div S] + VD) \times .02$

Republican candidate's signature requirement: $([AR \div S] + VR) \times .02$

AD = the number of absentee votes received in the entire county by the Democratic party's candidate for governor or for president of the United States in the previous general election.

AR = the number of absentee votes received in the entire county by the Republican party's candidate for governor or for president of the United States in the previous general election.

S = the number of supervisor districts in the county (3 or 5).

VD = the number of votes cast in the supervisor district for the Democratic party's candidate for governor or for president of the United States in the previous general election. (If this number is 5,000 or more, the minimum number of signatures needed is 100.)

VR = the number of votes cast in the supervisor district for the Republican party's candidate for governor or for president of the United States in the previous general election. (If this number is 5,000 or more, the minimum number of signatures needed is 100.)

This rule is intended to implement Iowa Code section 43.20(1) "d."

721—21.601(43) Plan III supervisor district candidate signatures after a change in the number of supervisors. After the number of supervisors has been increased or decreased pursuant to Iowa Code section 331.203 or 331.204, the signatures for candidates at the next primary and general elections shall be calculated as follows:

21.601(1) Primary election. Divide the total number of votes cast in the county at the previous general election for the office of president or for governor, as applicable, by the number of supervisor districts and multiply the quotient by .02. If the result of the calculation is less than 100, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 100, the minimum requirement shall be 100 signatures.

21.601(2) Nominations by petition. If the effective date of the change in the number of districts was later than the date specified in Iowa Code section 45.1(6), divide the total number of registered voters in the county on the date specified in Iowa Code section 45.1(6) by the number of supervisor districts and multiply the quotient by .01. If the result of the calculation is less than 150, the result shall be the minimum number of signatures required. If the result of the calculation is greater than or equal to 150, the minimum requirement shall be 150 signatures.

721—21.602(43) Primary election—nominations by write-in votes for certain offices.

21.602(1) The process described in subrule 21.602(2) shall be used to determine whether the primary election is conclusive and a candidate was nominated for partisan offices that are:

a. Not mentioned in Iowa Code section 43.53 (township offices) or 43.66 (state representative and state senator), and

b. For which no candidate's name was printed on the primary election ballot, and

c. For which no candidate's name was printed on the primary election ballot in any previous primary election.

21.602(2) To be nominated by write-in votes, the person must receive at least 35 percent of the number of votes cast in the previous general election for that party's candidate for president of the United States or for governor, as the case may be, as follows:

a. Statewide office: 35 percent of votes cast statewide.

b. Congressional district: 35 percent of votes cast within the current boundaries of the Congressional district.

- c.* County office, including plan II supervisors: 35 percent of the votes cast within the county.
- d.* Plan III county supervisor: 35 percent of the votes cast within the supervisor district. If the boundaries of the supervisor district have changed since the previous general election, the number of votes cast within the county for the party candidate for president or for governor, as the case may be, shall be divided by the number of supervisor districts in the county; then the quotient shall be multiplied by 0.35.

21.602(3) If a write-in candidate is declared nominated at the canvass of votes, Iowa Code section 43.67, which requires the appropriate election commissioner to notify the candidate, shall apply.

This rule is intended to implement Iowa Code section 43.66.

721—21.603 to 21.799 Reserved.

721—21.800(423B) Local sales and services tax elections.

21.800(1) Petitions requesting imposition, rate change, use change, or repeal of local sales and services taxes shall be filed with the county board of supervisors.

a. Each person signing the petition shall include the person's address (including street number, if any) and the date that the person signed the petition.

b. Within 30 days after receipt of the petition, the supervisors shall provide written notice to the county commissioner of elections directing that an election be held to present to the voters of the entire county the question of imposition, rate change, use change, or repeal of a local sales and services tax. In the notice the supervisors shall include the date of the election.

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph “c,” but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.800(2) As an alternative to the method of initiating a local option tax election described in subrule 21.800(1), governing bodies of cities and the county may initiate a local option tax election by filing motions with the county auditor pursuant to Iowa Code section 423B.1, subsection 4, paragraph “b,” requesting submission of a local option tax imposition, rate change, use change, or repeal to the qualified electors. Within 30 days of receiving a sufficient number of motions, the county commissioner shall notify affected jurisdictions of the local option tax election date. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph “c,” but no sooner than 84 days after the date upon which the commissioner received the motion triggering the election.

21.800(3) Notice of local sales and services tax election.

a. Not less than 60 days before the date that a local sales and services tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include sample ballots, but shall include all of the information that will appear on the ballot for each city and for the voters in the unincorporated areas of the county.

b. The city councils and the supervisors shall provide to the county commissioner the following information to be included in the notice and on the ballots for imposition elections:

(1) The rate of the tax.

(2) The date the tax will be imposed (which shall be the next implementation date provided in Iowa Code section 423B.6 following the date of the election and at least 90 days after the date of the election, except that an election to impose a local option tax on a date immediately following the scheduled repeal date of an existing similar tax may be held at any time that otherwise complies with the requirements of Iowa Code chapter 423B). The imposition date shall be uniform in all areas of the county voting on the tax at the same election.

(3) The approximate amount of local option tax revenues that will be used for property tax relief in the jurisdiction.

(4) A statement of the specific purposes other than property tax relief for which revenues will be expended in the jurisdiction.

A local sales and services tax shall be imposed in the [city of _____]
[unincorporated area of the county of _____] at the rate of _____ percent
(_____ %) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the
unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the
county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be
expended is (are):

(List specific purpose or purposes)

b. Imposition question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED?

YES

NO

Summary: To authorize imposition of a local sales and services tax in the cities of
_____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____ %) to be effective on _____ (month and day),
_____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____,
_____, _____, (list additional cities, if applicable) at the rate of _____
percent (_____ %) to be effective on _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be
expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be
expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

c. Imposition question with an automatic repeal date for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES NO

Summary: To authorize imposition of a local sales and services tax in the [city of _____] [unincorporated area of the county of _____], at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the [city of _____] [unincorporated area of the county of _____] at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

d. Imposition question with an automatic repeal date for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES NO

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special

paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

A local sales and services tax shall be imposed in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____ %) to be effective from _____ (month and day), _____ (year), until _____ (month and day), _____ (year).

Revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)
The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):
(List specific purpose or purposes)

e. Repeal question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES
NO

Summary: To authorize repeal of the _____ percent (_____ %) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The _____ percent (_____ %) local sales and services tax shall be repealed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

f. Repeal question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES
NO

Summary: To authorize repeal of the ____ percent (____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The ____ percent (____%) local sales and services tax shall be repealed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax have been allocated as follows:

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

FOR THE CITY OF _____:
_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues were otherwise expended was (were):

(List specific purpose or purposes)

g. Rate change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES
NO

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to _____ percent (_____%) in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year). The current rate is _____ percent (_____%).

Revenues from the sales and services tax are allocated as follows:
(Choose one or more of the following:)

- [_____ for property tax relief (insert percentage or dollar amount)]
- [_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]
- [_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

h. Rate change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES
NO

Summary: To authorize an increase (or decrease) in the rate of the local sales and services tax to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The rate of the local sales and services tax shall be increased (or decreased) to _____ percent (_____%) in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

Revenues from the sales and services tax are allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

i. Use change question for voters in a single city or the unincorporated area of the county:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES
NO

Summary: To authorize a change in the use of the _____ percent (_____%) local sales and services tax in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (_____%) local sales and services tax shall be changed in the [city of _____] [unincorporated area of the county of _____] effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax shall be allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

Revenues from the sales and services tax are currently allocated as follows:

(Choose one or more of the following:)

[_____ for property tax relief (insert percentage or dollar amount)]

[_____ for property tax relief (insert percentage or dollar amount) in the unincorporated area of the county of _____]

[_____ for property tax relief (insert percentage or dollar amount) in the county of _____]

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

j. Use change question for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED?

YES

NO

Summary: To authorize a change in the use of the _____ percent (____%) local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

(Insert in substantially the following form the entire text of the proposed public measure immediately below the summary on all paper ballots as provided in Iowa Code section 49.45. Counties using special paper ballots which are read by computerized tabulating equipment may summarize the question on the ballot and post the complete text as provided in Iowa Code section 52.25 as amended by 2009 Iowa Acts, House File 475.)

The use of the _____ percent (____%) local sales and services tax shall be changed in the cities of _____, _____, _____, (list additional cities, if applicable) effective _____ (month and day), _____ (year).

PROPOSED USES OF THE TAX:

If the change is approved, revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

(List specific purpose or purposes)

CURRENT USES OF THE TAX:

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

FOR THE CITY OF _____:

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues are otherwise expended is (are):

(List specific purpose or purposes)

k. Imposition question with differing automatic repeal dates for voters in contiguous cities:

(Insert letter to be assigned by the commissioner)

SHALL THE FOLLOWING PUBLIC MEASURE BE ADOPTED? YES
NO

Summary: To authorize imposition of a local sales and services tax in the cities of _____, _____, _____, (list additional cities, if applicable) at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until automatic repeal date specified.

A local sales and services tax shall be imposed in the following cities at the rate of _____ percent (_____%) to be effective from _____ (month/day/year) until the date specified below and the revenues from the sales and services tax are to be allocated as follows:

FOR THE CITY OF _____:

The tax shall be repealed on _____ (month/day/year).

_____ for property tax relief (insert percentage or dollar amount)

The specific purpose (or purposes) for which the revenues shall otherwise be expended is (are):

FOR THE CITY OF _____:

c. The election shall be held on the first possible special election date for counties set forth in Iowa Code section 39.2, subsection 4, paragraph “c,” but no sooner than 84 days after the date upon which notice is given to the commissioner.

21.802(2) Notice of local vehicle tax election. Not less than 60 days before the date that a local vehicle tax election will be held, the county commissioner of elections shall publish notice of the ballot proposition. The notice does not need to include a sample ballot, but shall include all of the information that will appear on the ballot. The notice of election provided for in Iowa Code section 49.53 as amended by 2009 Iowa Acts, House File 475, shall also be published at the time and in the manner specified in that section.

[ARC 8045B, IAB 8/26/09, effective 7/27/09]

721—21.803(82GA, HF2663) Revenue purpose statement ballots. When a school district wishes to adopt, amend or extend the revenue purpose statement specifying the uses of the funds received from the secure an advanced vision for education fund, which is also referred to as the “penny sales and services tax for schools,” the following ballot formats shall be used.

21.803(1) *Ballot to propose a revenue purpose statement.* The ballot for an election to propose a revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

- YES
- NO

Summary: To adopt a revenue purpose statement specifying the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the following revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be adopted:

(Insert here the revenue purpose statement that was adopted by the school board and that states the intended uses of the funds by the school district. The use or uses must be among the approved uses of the tax that are authorized by 2008 Iowa Acts, House File 2663, section 29.)

21.803(2) *Ballot to amend a revenue purpose statement.* The ballot for an election to decide a change in the revenue purpose statement specifying the use of funds received from the secure an advanced vision for education fund shall be in substantially the following form:

(Insert letter to be assigned by the commissioner.)

Shall the following public measure be adopted?

- YES
- NO

Summary: To authorize a change in the use of money from the penny sales and services tax for schools received by _____ School District.

In the _____ School District, the revenue purpose statement, which specifies the use of the penny sales and services tax for schools (sales and services tax funds from the secure an advanced vision for education fund for school infrastructure) shall be changed.

Proposed uses. If the change is approved, the revenue purpose statement shall read as follows:

supervisors and shall be substantially in the form posted on the state commissioner’s Web site titled “Petition Requesting Special Election.”

a. Within 10 days after receipt of a valid petition, the supervisors shall provide written notice to the county commissioner of elections directing the commissioner to submit to the qualified electors of the county a proposition to approve or disapprove the conduct of gambling games on an excursion gambling boat or at a gambling structure in the county. The election shall be held on the next possible special election date pursuant to Iowa Code section 39.2, subsection 4, paragraph “a,” but no fewer than 46 days from the date notice is given to the county commissioner.

b. If a regularly scheduled or special election is to be held in the county on the date selected by the supervisors, notice shall be given to the commissioner no later than the last day upon which nomination papers may be filed for that election. If the excursion gambling boat or the gambling structure election is to be held with a local option tax election, the supervisors shall provide the commissioner at least 60 days’ written notice. Otherwise, the supervisors shall give at least 46 days’ written notice.

21.820(2) Form of ballot for election called by petition. Ballots shall be in substantially the following form:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

- YES
- NO

Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

21.820(3) Form of ballot for elections to continue gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

- YES
- NO

Summary: Gambling games on an excursion gambling boat or at a gambling structure in _____ County are approved.

Gambling games, with no wager or loss limits, on an excursion gambling boat or at a gambling structure in _____ County are approved. If approved by a majority of the voters, operation of gambling games with no wager or loss limits may continue until the question is voted upon again at the general election held in 2010. If disapproved by a majority of the voters, the operation of gambling games on an excursion gambling boat or at a gambling structure will end within 60 days of this election. (Iowa Code section 99F.7(10) “c”)

21.820(4) Ballot form to permit gambling games at existing pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

- YES
- NO

The operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

21.820(5) Abstract of votes. A copy of the abstract of votes of the election shall be sent to the state racing and gaming commission.

21.820(6) Ballot form for general election for continuing operation of gambling games at pari-mutuel racetracks:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

- YES
- NO

Summary: The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved.

The continued operation of gambling games at (name of pari-mutuel racetrack) in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue at (name of pari-mutuel racetrack) in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of the voters, gambling games at (name of pari-mutuel racetrack) in _____ County will end.

21.820(7) Ballot form for general election for continuing gambling games on an excursion gambling boat or at a gambling structure:

(Insert letter to be assigned by the commissioner)

Shall the following public measure be adopted?

- YES
- NO

Summary: The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved.

The continued operation of gambling games on an excursion gambling boat or at a gambling structure in _____ County is approved. If approved by a majority of the voters, operation of gambling games may continue on an excursion gambling boat or at a gambling structure in _____ County until the question is voted on again at the general election in eight years. If disapproved by a majority of voters, gambling games on an excursion gambling boat or at a gambling structure in _____ County will end nine years from the date of the original issue of the license to the current licensee.

This rule is intended to implement Iowa Code section 99F.7 and Iowa Code Supplement section 99F.4D.

[ARC 8045B, IAB 8/26/09, effective 7/27/09; ARC 8779B, IAB 6/2/10, effective 7/1/10]

721—21.821 to 21.829 Reserved.

721—21.830(357E) Benefited recreational lake district elections. Elections for benefited recreational lake districts shall be conducted according to the following procedures.

21.830(1) Conduct of election. It is not mandatory for the county commissioner of elections to conduct elections for a benefited recreational lake district. However, if both a public measure and a candidate election will be held on the same day in a benefited recreational lake district, the same person shall be responsible for conducting both elections. All elections must be held on a Tuesday.

21.830(2) Ballots. Ballots for benefited recreational lake district trustee elections shall be printed on opaque white paper, 8 by 11 inches in size. The ballots for the initial election for the office of trustee shall be in substantially the following form:

OFFICIAL BALLOT
BENEFITED RECREATIONAL LAKE DISTRICT
Election date

(facsimile signature of person responsible for printing ballots)

FOR TRUSTEE:

To vote: Neatly print the names of at least three people you would like to see elected to the office of Trustee of the Benefited Recreational Lake District. You may vote for as many people as you wish, but you must vote for at least three.

(At the bottom of the ballot a space shall be included for the endorsement of the precinct election official, like this:)

Precinct official's endorsement: _____

21.830(3) *Canvass of votes.* On the Monday following the election, the board of supervisors shall canvass the votes cast at the election. At the initial election the supervisors shall choose three trustees from among the five persons who received the most votes. The results of benefited recreational lake district elections shall be certified to the district board of trustees.

This rule is intended to implement Iowa Code section 357E.8.

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- [Filed Emergency ARC 8777B, IAB 6/2/10, effective 5/7/10]
- [Filed Emergency ARC 9049B, IAB 9/8/10, effective 8/16/10]
- [Filed Emergency ARC 9139B, IAB 10/6/10, effective 9/16/10]
- [Filed Emergency ARC 9466B, IAB 4/20/11, effective 3/31/11]

[◇] Two or more ARCs

CHAPTER 22
VOTING SYSTEMS

[Prior to 7/13/88, see Secretary of State[750] Ch 10]

TESTING AND EXAMINATION OF VOTING EQUIPMENT

721—22.1(52) Definitions for certification of voting equipment.

“*Accredited independent test authority*” means a person or agency that was formally recognized by the National Association of State Election Directors as competent to design and perform qualification tests for voting system hardware and software. “Accredited independent test authority” also includes voting system test laboratories accredited by the Election Assistance Commission to test voting systems for compliance with federal voting system standards and guidelines, as required by the Help America Vote Act, Section 231.

“*Audio ballot*” means the presentation of the contents of a ballot on an electronic ballot marking device in a recorded format, played to the voter over headphones.

“*Automatic tabulating equipment*” means apparatus that are utilized to ascertain the manner in which optical scan ballots have been marked by voters or by electronic ballot marking devices and to count the votes marked on the ballots.

“*Ballot*” means the official document that includes all of the offices or public measures to be voted upon at a single election, whether they appear on one or more paper ballots. The term includes optical scan paper ballots designed to be read by automatic tabulating equipment. In appropriate contexts, “ballot” also includes conventional paper ballots.

“*Ballot marking device*” means a pen, pencil, or similar writing tool, or an electronic device, all designed for use in marking an optical scan ballot, and so designed or fabricated that the mark it leaves may be detected and the vote so cast counted by automatic tabulating equipment.

“*Certification*” means formal approval of an optical scan voting system for use in Iowa pursuant to Iowa Code sections 52.5 and 52.26.

“*De minimis change*” means a change to a certified voting system’s hardware, the nature of which will not materially alter the system’s reliability, functionality, capability, security and operation. In order for a change to qualify as a de minimis change, it must not alter the reliability, functionality, capability, security and operability of the system. A de minimis change shall also ensure that when the hardware is replaced, the original hardware and the replacement hardware are electronically and mechanically interchangeable and have identical functionality and tolerances. A change shall not be considered de minimis if it has reasonable and identifiable potential to affect the system’s operation and compliance with applicable voting system standards.

“*Early voting*” means the process of receiving ballots from voters before election day without using absentee voting procedures. Iowa law does not authorize this process.

“*Electronic ballot marking device*” means a component of an optical scan voting system designed to assist voters with disabilities by displaying audio and visual ballot information to the voter, providing accessible methods for the voter to make selections, and then printing the voter’s choices on an optical scan ballot.

“*Electronic transmission*” means using hardware and software components to send data over distances both within and external to the polling place and to receive an accurate copy of the transmission.

“*Examiners*” means the board of examiners for voting systems described in Iowa Code section 52.4.

“*Modification*” means a change to a certified voting system’s software or firmware. Modification also means a change to a certified voting system’s hardware that has the potential to affect the reliability, functionality, capability, security or operability of a system.

“*Optical scan ballot*” means a printed ballot designed to be marked by a voter with a ballot marking device and to be counted by use of automatic tabulating equipment.

“*Optical scan voting system*” means a system employing paper ballots under which votes are cast by voters by marking paper ballots with a ballot marking device and thereafter counted by use of automatic tabulating equipment.

“*Program*” means the written record of the set of instructions defining the operations to be performed by a computer in examining, counting, tabulating, and printing votes.

“*Qualification test*” means the examination and testing of a voting system by an independent test authority using the voting system standards required by Iowa Code section 52.5 and rule 721—22.2(52) to determine whether the system complies with those standards.

“*Vendor*” means a person or representative of a person owning or being interested in an optical scan voting system and seeking certification of the equipment for use in elections in Iowa.

“*Voting booth*” means an enclosure designed to be used by a voter while marking a conventional paper ballot, optical scan ballot or ballot card.

“*Voting equipment*” means an optical scan voting system which is required by Iowa Code sections 52.5 and 52.26 to be approved for use by the examiners.

“*Voting system*” means the total combination of mechanical, electromechanical or electronic equipment (including the software, firmware and documentation required to program, control and support the equipment that is used to define ballots, to cast and count votes, to report or display election results and to maintain and produce any audit trail information). “Voting system” also includes the practices and associated documentation used to identify system components and versions of such components, to test the system during its development and maintenance, to maintain records of system errors and defects, to determine specific system changes to be made to a system after the initial qualification of the system and to make available any materials to the voter such as notices, instructions, forms or paper ballots. (See Section 301(b) of HAVA.)

[ARC 8244B, IAB 10/21/09, effective 10/2/09; ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.2(52) Voting system standards. All electronic voting systems approved for use by the board of examiners after April 9, 2003, shall meet Voting Systems Performance and Test Standards, as adopted by the Federal Election Commission April 30, 2002. The report of an accredited independent test authority certifying that the system is in compliance with these standards shall be submitted with the application for examination.

This rule is intended to implement Iowa Code section 52.5.
[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.3(52) Examiners. The examiners annually shall elect a chairperson. All three examiners must be present for any formal action. Approval by two of the three examiners is required to approve any action to be taken by the examiners.

22.3(1) Notice of the time and place of any meeting by the board of examiners must be published pursuant to Iowa Code section 21.4.

22.3(2) Meetings of the examiners are open to the public, except that closed meetings may be held as permitted by Iowa Code section 21.5.

22.3(3) Correspondence and materials required to be filed with the board of examiners shall be addressed to the examiners in care of the Elections Division, Office of the Secretary of State, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

721—22.4(52) Fees and expenses paid to the examiners.

22.4(1) The examiners shall be reimbursed for travel to and from the meeting place at the rate specified in Iowa Code section 70A.9. The examiners shall also be reimbursed for actual expenses for meals and lodging, if necessary.

a. If the meeting was called for the purpose of examining, reexamining, testing, or discussing the certification of voting equipment offered by a vendor, the examiners’ expenses shall be paid by the vendor within seven days following the completion of the examination and testing of the voting equipment.

b. If the meeting was called for the purpose of advising the secretary of state regarding administrative rules for the examiners, or to hear complaints or requests for decertification of voting

equipment, or any other business of interest to the examiners, the expenses shall be paid by the secretary of state.

22.4(2) The vendor shall pay the examiners the amount of compensation specified in Iowa Code section 52.6 at the beginning of each meeting for which compensation is required to be provided to the examiners. The fee shall be paid as follows:

a. For each meeting or series of meetings held for the purpose of certifying an optical scan voting system or component thereof.

b. For each meeting or series of meetings for reconsideration of an optical scan voting system or component thereof after denial of certification.

This rule is intended to implement Iowa Code sections 17A.19, 49.25(3), 52.5, 52.6, and 52.26.
[ARC 8244B, IAB 10/21/09, effective 10/2/09]

721—22.5(52) Examination of voting equipment—application. Any vendor who wishes to apply for certification of voting equipment for use in the state of Iowa shall apply to the secretary of state for an appointment with the examiners. The application shall include five copies of each of the following:

22.5(1) History of the equipment to be examined. This history shall include a complete description of the equipment to be examined, descriptions of any previous models of the equipment, the date the system to be examined went into production, and a complete list of jurisdictions which have used the equipment. The user list shall include jurisdictions which used the equipment experimentally without purchasing it, jurisdictions which purchased earlier versions of the equipment to be examined, and jurisdictions which purchased the current version of the equipment to be examined.

22.5(2) Copies of all manuals developed for use with the system including, but not limited to, technical manuals for repair and maintenance of the equipment, operations manuals for election officials, printer's manuals for ballot production, and any other written documents prepared by the vendor that describe the operation, use, and maintenance of the machine.

22.5(3) Report of an accredited independent test authority certifying that the system is in compliance with the voting systems standards required by rule 721—22.2(52). Copies of these reports are confidential records as defined by Iowa Code section 22.7 and Iowa Code chapter 550. Independent test authority reports shall be available to the secretary of state, deputy secretary of state, director of elections, members of the board of examiners, and any other person designated by the secretary of state to have a bona fide need to review the report. No other person shall have access to the reports, and no copies shall be made. All independent test authority reports shall be marked "CONFIDENTIAL" and shall also be accompanied by a list of those persons who are authorized to examine the report. The reports shall be kept in a locked cabinet.

22.5(4) Copies of the reports of any test authority who has examined the equipment in conjunction with certification requirements of other states.

22.5(5) Reports of the certifying authorities of any other states that have examined the equipment, whether or not the equipment was approved for use.

22.5(6) Brochures, photographs and advertising material used to encourage sales of the equipment.

22.5(7) Manuals for the use and maintenance of any components of the equipment that are not manufactured by the vendor.

22.5(8) Rescinded IAB 4/20/11, effective 5/25/11.

22.5(9) Reserved.

22.5(10) The form prescribed by the state commissioner of elections to request examination and testing of voting systems.

[ARC 8244B, IAB 10/21/09, effective 10/2/09; ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.6(52) Review of application by examiners. Upon receipt of the application, the secretary of state shall immediately forward copies of the application to each of the examiners. The examiners shall review the application and within seven days a date shall be set for the examiners to meet and examine the equipment. If additional information is needed by the examiners, they may delay setting a date for the examination pending the submission of the requested materials.

721—22.7(52) Consultant. If the examiners determine that a consultant is necessary to determine whether a system meets the requirements of Iowa law or whether a change to a voting system is de minimis or a modification, the examiners shall notify the vendor of the decision. The vendor may suggest the names of reliable independent test authorities to the examiners and may decline to submit the equipment to the examination of an individual for good reason.

A consultant may be employed if no other state has certified the equipment for use. The examiners may require a consultant if the equipment has been modified following certification by other states, or if the examiners believe it to be necessary.

If a test authority has been determined to be necessary by the examiners and a suitable consultant cannot be agreed upon by the examiners and the vendor, the equipment shall not be approved for use.
[ARC 8244B, IAB 10/21/09, effective 10/2/09]

721—22.8(52) Contact other users. The examiners shall contact a representative sample of the users of the equipment to determine the nature of the experience of other users.

721—22.9(52) Testing the equipment. The vendor shall provide to the examiners one, or more, if deemed necessary by the examiners, production models of the equipment submitted for certification. The equipment shall be prepared by the examiners with the aid of the vendor to be tested at two sample elections: a sample partisan primary election, and a sample general election.

22.9(1) Test county for absentee voting. Voting equipment which is designed to be used for tabulation of absentee ballots shall be tested using a model county consisting of 155 precincts, with 180,000 registered voters. The county shall include one U.S. congressional district, five state senate districts, 11 state house of representatives districts, and 30 townships. Each township shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(2) Test county for absentee systems. Voting equipment which is designed to be used for tabulation of absentee ballots only shall be tested using a model county consisting of 155 precincts, with 180,000 registered voters. The county shall include one U.S. Congressional District, five state senate districts, 11 state house of representatives districts, and 30 townships. Each township shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(3) Test precinct for precinct count systems. The test precinct shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(4) All requirements for preparation and printing of test ballots shall be met in the preparation of ballots for the test elections including, but not limited to, rotation of candidates' names and the provision of space for write-in votes.

22.9(5) Test ballots provided by vendor. The vendor shall provide the ballots to be used in the testing of the equipment. A total of at least 2000 ballots shall be printed for each of the two test elections. One thousand ballots for each test election shall be marked and manually tabulated by the vendor to use as a test of the ability to tabulate results accurately. The balance of the ballots shall be delivered to the examiners before the date set for the examination. The examiners shall mark and manually tabulate an additional set of at least 300 test ballots.

721—22.10(52) Test primary election for three political parties.

22.10(1) Closed primary election. Voters may only cast votes for the candidates of one of the parties.

22.10(2) Offices. The following offices shall each have two candidates for each party. Candidate names shall be rotated as required by Iowa Code section 43.28.

- a. U.S. Senator
- b. U.S. Representative
- c. Governor
- d. Secretary of State

- e. Auditor of State
- f. Treasurer of State
- g. Secretary of Agriculture
- h. Attorney General
- i. State Senator
- j. State Representative
- k. County Supervisor (vote for no more than three of six candidates)
- l. County Treasurer
- m. County Recorder
- n. County Attorney
- o. and p. Rescinded IAB 8/1/07, effective 7/13/07.

22.10(3) Write-in votes. Spaces for write-in votes shall be provided for each office on the ballot. The number of spaces shall equal the number of persons to be elected to the office.

721—22.11(52) Test general election. The ballots for the test general election shall include the following:

22.11(1) Offices. In the test general election all of the above offices shall be included with the addition of candidates for lieutenant governor to be voted for jointly with each candidate for governor. Each political party and nonparty political organization shall have one candidate for each office that appeared on the primary ballot, except county supervisor, which shall have three candidates for each party and nonparty political organization. Names of candidates for county supervisor shall be rotated as required by Iowa Code section 49.31, subsection 2.

The following nonpartisan offices shall also be included on the ballot with the heading “Nominated by Petition”:

- a. Township Trustee
- b. Township Clerk
- c. County Public Hospital Trustee
- d. Soil and Water Conservation District Commissioners
- e. Agricultural Extension Council

22.11(2) Judicial ballot. Portions of the judicial ballot may be printed separately if necessary.

- a. Supreme Court (five justices)
- b. Appeals (four judges)
- c. District Court (six judges)
- d. District Associate Judges (three judges)

22.11(3) Public measures.

- a. Constitutional Amendments (two)
- b. Local public measures (three)

22.11(4) Straight party voting for three political parties and five nonparty political organizations.

22.11(5) Write-in votes. Spaces for write-in votes shall be provided for each office on the ballot. The number of spaces shall equal the number of persons to be elected to the office. This does not include judges standing for retention.

721—22.12(52) Report of findings. The examiners shall complete a report showing their findings. The report shall include a checklist containing all statutory requirements for voting systems and shall indicate whether each requirement applies to the voting system being examined and whether the voting system is compliant or not compliant. The checklist must indicate that all applicable items are compliant with statutory requirements in order for the examiners to find that the voting system may be approved for use.

22.12(1) Approval permits use. If the report states that the voting system has been approved for use, the voting system may be adopted for use at elections.

22.12(2) Report filed with the secretary of state. The report shall be filed with the secretary of state. The secretary of state shall retain the vendor’s application and other documents submitted pertaining to the certification as long as the voting system remains certified.

721—22.13(52) Notification. The examiners shall promptly notify the vendor of their decision and shall provide the vendor with a copy of their report.

721—22.14(52) Denial of certification. If the examiners find that the equipment does not meet the requirements prescribed by the Code of Iowa and the Iowa Administrative Code, the examiners shall deny certification to the equipment. The report of the board shall specify the reasons for the denial, as well as all areas in which the equipment complied with the requirements of the law. Certification may be denied for any of the following reasons:

22.14(1) The absence of any feature required by Iowa Code section 52.5 or 52.26.

22.14(2) Failure to pay the examiners' fees and expenses, or the fees of any consultant mutually agreed upon by the examiners and the vendor.

22.14(3) Failure to provide the examiners with a complete application as required by rule 721—22.5(52).

22.14(4) Failure of the equipment to produce accurate results in one or both of the test elections. The test groups of ballots shall be tabulated manually to determine the expected outcome of each test election. If the equipment fails to reproduce exactly the results of the manual tabulation, the system shall not be approved for use, unless it can be demonstrated that the manual tabulation was in error and the machine tabulation was accurate.

[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.15(52) Application for reconsideration. Following denial of certification a vendor may make the necessary modifications to the system and apply for reconsideration. Aspects of the equipment which were approved in the initial application do not need to be reexamined unless the examiners find that the modifications may have affected the ability of the equipment to comply in other areas. If certification was denied for the reasons cited in 22.14(1) or 22.14(4), both test elections must be completed satisfactorily, or approval shall not be granted.

721—22.16(52) Appeal. If the vendor believes the denial of certification is in error, the vendor must file written exceptions with the examiners within 30 days after issuance of the report. The examiners will issue a response to the exceptions within 30 days after filing of the exceptions. A vendor who is aggrieved or adversely affected by a denial after a ruling on exceptions may seek judicial review pursuant to Iowa Code section 17A.19.

721—22.17(52) Changes to certified voting systems. The procedures in this rule shall be followed anytime a change is made to a certified voting system, including a change in tabulation software, firmware, or hardware.

22.17(1) Notification of change. The vendor shall notify the examiners of any changes in a certified voting system. The vendor shall provide the examiners with the following information at the time the vendor provides notice of the change(s):

a. A description of the changes made.

b. Reports of test results conducted by an accredited independent test authority, and any reports of test results conducted by or for other states following the changes to the voting system.

c. Copies of manuals, instructions, advertisements and other documents submitted with the voting system's original application for certification that have been updated since the original application was submitted.

d. An assessment from an accredited independent test authority of the change as either a de minimis change or a modification to the voting system.

22.17(2) Commencing review proceedings. Within seven days of receiving a voting system change notice from a vendor, the examiners shall commence review proceedings to independently determine whether the change submitted by the vendor is a de minimis change or a modification to the voting system. In making this independent determination, the examiners may use any means available, including hiring a consultant pursuant to rule 721—22.7(52).

22.17(3) *De minimis changes.* If the examiners determine a change to a voting system is de minimis, the examiners may approve the changes by motion and certify the changed voting system for use in the state.

22.17(4) *Modifications to voting systems.* If the examiners determine a change to a voting system is a modification to the voting system, the examiners shall require the vendor to submit a new application for certification and testing of the voting system pursuant to rules 721—22.5(52) to 721—22.11(52). [ARC 8244B, IAB 10/21/09, effective 10/2/09]

721—22.18(52) Rescinding certification.

22.18(1) *Grounds for rescinding certification.* Certification may be rescinded if it is found that:

a. The equipment does not produce accurate results and reports as required for an election.
b. Modifications have been made in a certified voting system that have not been approved by the examiners.

c. Equipment which has been certified for use has not been adopted by any county in Iowa, or is no longer used by any county in Iowa, and is no longer available for purchase from the manufacturer. The examiners may rescind certification of such voting equipment without a complaint or contested case proceedings.

d. Equipment that has been certified for use no longer complies with the requirements of Iowa law.

e. Any other grounds that may materially affect delivery or performance of the equipment.

22.18(2) *Procedure for rescinding certification.* Complaints regarding voting equipment certified for use in Iowa shall be filed with the secretary of state. The examiners shall review all complaints and may initiate a contested case to rescind certification on any ground listed above. The contested case may be conducted before the examiners or before an administrative law judge. A contested case for rescinding certification shall be conducted, to the extent applicable, in accordance with the procedural rules specified in 481—Chapter 10, Iowa Administrative Code.

22.18(3) *Suspension of certification.* If the administrative law judge hearing the contested case, or the examiners, as the case may be, find that the voting equipment can be modified to correct the deficiency, certification may be suspended until the deficiency is corrected. If it is found that the deficiency is limited to a specific flaw not present in all models of the equipment, the suspension may be limited to the deficient models. While certification is suspended, the equipment may not be used for any election.

After the required modifications have been made the vendor may apply for reexamination of the equipment following the procedure described in rule 721—22.17(52).

22.18(4) *Further use prohibited.* If certification of voting equipment is rescinded without qualification, no further use shall be permitted by any county.

[ARC 8244B, IAB 10/21/09, effective 10/2/09]

These rules are intended to implement Iowa Code sections 17A.12, 21.4, 21.5, 52.4, 52.5, 52.6, 52.7, 52.26, and 70A.9.

721—22.19(52) Examination of voting booths—application. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.20(52) Review of application by examiners. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.21(52) Contact other users. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.22(52) Criteria for approval. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.23(52) Report. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.24(52) Notification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.25(52) Denial of certification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.26(52) Application for reconsideration. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.27(52) Appeal. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.28(52) Reexamination following changes in voting booth. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.29(52) Rescinding certification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.30(50,52) Electronic transmission of election results.

22.30(1) Certification of equipment. On or after December 17, 2003, new components for transmission of election results by any electronic means may be used in elections in Iowa only if the components are approved by the board of examiners for use with a certified voting system. Existing systems containing electronic transmission components in use before December 17, 2003, may continue to be used until January 1, 2006, when the Help America Vote Act voting system requirements become effective.

The examiners shall review the qualification test report submitted with the application for examination and testing of the voting system. If the test report for the voting system under examination shows that the electronic transmission components have met the voting system standards and the examiners concur, the electronic transmission components may be used in conjunction with the voting system. If the qualification test report or the examiners conclude that the electronic transmission components do not meet the voting system standards, or if this feature is not mentioned in the report, purchasers of the voting system may not transmit election results electronically.

22.30(2) Procedures on election day. The election results may be transmitted electronically from voting equipment to the county commissioner of elections' office only after the precinct election officials have produced a written report of the election results as required by Iowa Code section 50.11. All election officials of the precinct shall sign the printed report of the election results. The signed copy shall be the official tabulation from that precinct.

22.30(3) Procedures after election day. Before the canvass by the board of supervisors, the county commissioner of elections shall compare the signed, printed report from each precinct with the results transmitted electronically from the precinct on election night. The commissioner shall report any discrepancies between the two sets of election results to the board of supervisors. The signed, printed results produced pursuant to Iowa Code section 50.11 shall be considered the correct results.

This rule is intended to implement Iowa Code sections 50.11 and 52.41.

721—22.31(52) Acceptance testing. When the commissioner receives voting equipment from a vendor, the commissioner shall carefully examine and test the equipment to:

22.31(1) Verify that the system delivered is certified for use in Iowa. The commissioner shall compare the voting system version numbers with the list of certified voting equipment provided by the state commissioner;

22.31(2) Verify that everything in the contract has been delivered by:

- a. Comparing a copy of the purchase contract with the items received;
- b. Making certain that all components, such as power cords, casters, and keys, are included;
- c. Reviewing instruction and maintenance manuals to be sure that the correct version of each manual was provided; and

22.31(3) Verify that everything delivered actually works. The commissioner shall run a simulated election to confirm that each part of the system and the system as a whole function properly.

721—22.32(52) Optical scan voting system purchase program. Rescinded IAB 4/20/11, effective 5/25/11.

721—22.33 to 22.38 Reserved.

721—22.39(52) Public testing for direct recording electronic voting machines. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.40(52) Public testing of lever voting machines. Rescinded IAB 8/1/07, effective 7/13/07.

721—22.41(52) Public testing of optical scan systems. All automatic tabulating equipment (including equipment used to tabulate absentee ballots) shall be tested before use at any election, as required by Iowa Code section 52.35. The process and results of the test shall be documented and available for inspection.

22.41(1) Each automatic tabulating device (including equipment that will be used for counting absentee ballots) shall be tested to determine the following:

a. The device and its programs will accurately tabulate votes for each candidate and question on the ballot.

b. Votes cast for more candidates for any office than the number to be elected will result in the rejection of all votes cast for that office on that ballot. Votes properly cast for other offices on the same ballot shall be counted.

c. The tabulating equipment records all votes cast and no others. A written tally of the test votes shall be prepared before the test. The results of the test voting shall be recorded. The results of the machine tabulation shall be printed and compared with the test plan.

d. The voter may cast as many write-in votes for each office on the ballot as there are positions to be filled, and the write-in votes are tallied correctly.

e. For primary elections, the tabulating equipment accurately records votes cast for all political parties.

f. For general elections:

(1) A ballot marked with only a straight party vote is recorded with one vote for each candidate of the designated political party, and no other votes are recorded for partisan offices;

(2) The voter may override a straight party vote for any office by voting for any candidate not associated with that political party; and

(3) For offices to which more than one person will be elected, if a voter has chosen to override a straight party vote, only the candidates whose names are marked shall receive a vote.

22.41(2) Conducting the test.

a. The commissioner shall follow the process described in rule 721—22.42(52) for preparing test decks.

b. If, during the test, there are differences between the test plan and the results produced by the optical scan device, the cause of the discrepancy shall be determined. If the cause of the discrepancy cannot be determined and corrected, the faulty program or equipment shall not be used in the election.

c. The test decks, the preparer's tally, and the printed results of the test shall be kept with the records of the election and preserved as required by Iowa Code section 50.19.

721—22.42(52) Preparing test decks. The commissioner shall prepare test decks from all ballots printed for use in the election, including those for use at the polling places and for absentee balloting. Each of the following test decks shall be prepared for every precinct and ballot style in the election. Commissioners may use additional test methods to supplement the process described in this rule.

22.42(1) *Requirements for all test decks prepared by the commissioner and used in public testing.* The commissioner shall:

a. Replace ballots spoiled during the marking process instead of attempting to correct errors.

b. Fill in each oval completely using the recommended pen, pencil or AutoMARK VAT.

c. Mark each ballot "Test Ballot."

22.42(2) *Required test method.* The commissioner shall:

a. Prepare a test plan showing the planned number of votes, including undervotes and overvotes for each oval on the ballot. Follow the instructions in subrules 22.42(3) through 22.42(5) in preparing the test decks.

- b. Mark the test ballots according to the test plan.
- c. Print a zero totals report from the optical scan tabulator before inserting any ballots.
- d. Insert the ballots into the optical scan tabulator and print a report showing the number of votes recorded for all offices, questions and judges, including undervotes and overvotes.
- e. Compare the printed report with the test plan to ensure that the correct number of votes was counted for each oval.
- f. If the commissioner finds errors, the commissioner shall identify and correct them. The commissioner shall repeat the testing process until the printed results from the tabulator match the test plan. If the commissioner cannot produce an errorless test, the equipment shall not be used in the election.

22.42(3) Systematic test deck. The commissioner shall determine a unique number of votes for each candidate in each office, such as one vote for each write-in oval for the office, two votes for the first candidate listed (or “NO” votes on public measures and judges), three votes for the second candidate, etc. It is not necessary to have a different number of votes for each write-in oval for offices for which the voter may select more than one candidate. However, the write-in oval shall have a different number of votes marked than any candidate for the office. The commissioner shall:

- a. On general election ballots, leave the straight party choice blank.
- b. For offices without candidates, mark all of the write-in ovals for that office.
- c. For offices in which the voter may vote for more than one candidate, vote for the maximum allowed on at least one ballot.
- d. On a ballot that contains at least one valid vote, overvote one other office or question.

22.42(4) System-specific testing requirements. Separate tests are prescribed for each certified voting system.

a. *Election Systems & Software—overvote and blank ballot test.* For an overvote and blank ballot test, the commissioner shall:

(1) Overvote all offices and questions (including judges) on one ballot, by marking one more vote than permitted. Do not mark the write-in ovals for any offices for which there are no candidates’ names on the ballot.

(2) If the test is for ballots that will be used in a general election, mark two straight party votes on one ballot. Do not mark any other ovals. In the test plan, this ballot should be tallied to show that the straight party selection was overvoted, and to show undervotes for all other offices and questions on the ballot.

(3) When the overvoted ballots are rejected by the optical scan tabulator, override the rejection and include the ballot in the tally. Add to the manual tally the number of overvotes in this test. The tally for this part of the test deck will show no votes for any candidate.

(4) Insert a blank ballot. This is a very important test of the accuracy of ballot printing. Printing errors sometimes put readable marks in the voting target area.

(5) Orientation test. Mark the maximum number of choices for each office and question on one ballot.

Scan this ballot in each of the four possible orientations:

- Face up, head first.
- Face down, head first.
- Face up, feet first.
- Face down, feet first.

b. *Premier Election Solutions.*

(1) Blank and fully voted test. The commissioner shall use two ballots for this test.

1. Leave one ballot completely blank.

2. On the second ballot, mark every oval on both sides of the ballot.

3. Select “Test Blank Ballots” and insert the blank ballot in all four orientations:

- Face up, head first.
- Face down, head first.
- Face up, feet first.

- Face down, feet first.
 - 4. Select “Test Fully Voted Ballots” and insert the second ballot in each of the four orientations listed in numbered paragraph “3” above.
 - 5. Reinsert the blank ballot and the fully voted ballot and override the rejection feature.
- (2) Overvote. Overvote all offices and questions (including judges) on one ballot, by marking one more vote than permitted. Do not mark the write-in ovals for any offices for which there are no candidates’ names on the ballot.

22.42(5) *Straight party test for general elections.* For a straight party test, the commissioner shall:

- a. For each set of ballots:
 - (1) Mark straight party votes in a pattern, such as one vote for the first straight party choice, two votes for the second, and so on, and tally the expected results. Do not mark anything else on this group of ballots.
 - (2) On a second set of ballots containing as many ballots as there are straight party choices, mark the straight party option and, for each office affected by the straight party vote, mark the write-in oval, and tally the expected results.
 - (3) If the election includes an at-large county supervisor race with more than one person to be elected, mark a ballot with only a straight party vote and then vote for one candidate from the same political party as the straight party vote. Only this separately marked candidate should receive a vote.
- b. Compile the results of the straight party test deck.

721—22.43(52) Conducting the public test.

22.43(1) The equipment shall be inspected to determine whether it has been prepared properly for the election at which it will be used. The following information shall be verified:

- a. The correct program cartridge or memory card is in place for the election and the precinct or precincts in which it will be used.
- b. All counters are set at zero before the test is begun.

22.43(2) The commissioner shall conclude the test not later than 12 hours before the polls open on election day. Following the test, the tabulating equipment shall be inspected to determine that:

- a. All counters have been returned to zero.
- b. All required locks or seals are in place.
- c. The automatic tabulating equipment is ready for operation at the election.

The results tape from each scanner produced during the public test shall be signed by the person conducting the test and by any observers present at the test. The signers shall write their signatures at the end of the tape where it will be detached from the machine. The tape shall be torn or cut across the signatures, so that a portion of the signature is on the tape remaining on the tabulating device. The test results tape, including a part of the tester’s signature, shall be retained with the appropriate test deck for the period of time required by Iowa Code section 50.19.

22.43(3) Test deck submitted by observers. Any person who is present at the public test may mark ballots to be used to test the voting equipment. The following conditions apply:

- a. Not more than ten ballots may be submitted by any person.
- b. Only official ballots provided by the commissioner at the test shall be used.
- c. The observer submitting the test shall provide a written tally of the test deck.
- d. The results of the machine tabulation shall be printed and compared with the observer's tally. If there are differences, the cause of the discrepancy shall be determined. If the cause of the discrepancy cannot be determined and corrected, the program or equipment shall not be used at the election.
- e. The test decks, the tally, and the printed results of the test shall be kept with the records of the election and preserved as required by Iowa Code section 50.19.

Rules 721—22.41(52) through 721—22.43(52) are intended to implement Iowa Code section 52.35.

721—22.44 to 22.49 Reserved.

721—22.50(52) Voting system security. Each county shall have a written security policy. The policy shall include detailed plans to protect the election equipment and data from unauthorized access. The policy shall describe the methods to be used to preserve the integrity of the election and to document the election process.

22.50(1) Staff access. The security policy shall describe who shall have access to the voting equipment.

22.50(2) Computers. For security purposes, computers used in the commissioner's office to prepare ballots and voting equipment programs or to compile and report election results should not be used for any other function and should not be linked to any computer network or to the Internet.

a. If the election computers are linked to a network or to the Internet, the commissioner shall use a firewall to filter network traffic. Data transmissions over the Internet shall be encrypted and password-protected. Information posted to a Web site shall not be considered transmission of data over the Internet.

b. Access shall be limited to persons specified by the commissioner in the written security policy. The level of access shall be included in a written security policy.

(1) **Uniqueness.** Every ID and password shall be unique. The creation of generic or shared user IDs is specifically prohibited. Each user shall have exactly one user ID and password, except where job requirements necessitate the creation of multiple IDs to access different business functions.

(2) **Authority.** Each user shall be granted only the level of access specifically required by the user's job. Use of "Administrator," "Super User," "Security Administrator," or "SA" levels of authority shall be severely restricted.

(3) **Generic user IDs.** Staff members with generic user IDs are not allowed to sign on to voting systems.

(4) **Password standards.**

Account Policy	Recommended Setting
Maximum Password Age	90 days
Minimum Password Age	2 days
Minimum Password Length	8 characters
Enforced Password History	6 passwords (last 6 cannot be used)
Account Lockout (number of unsuccessful log-on attempts)	3 bad attempts
Account Lockout Duration	6 hours
Reset Account Lockout Counter After	6 hours

22.50(3) Evacuation. If it is necessary to evacuate the election office, a satellite absentee voting station or a polling place, the precinct election staff or the election officials shall immediately attempt to notify the commissioner and take the following actions:

a. Keep people safe.

b. If possible, gather and secure voted ballots, election equipment and critical election documents.

721—22.51(52) Memory cards. A memory card is a small, removable device containing data files of the election definition programmed for use in voting equipment for each election. For all voting equipment, the following security measures are required:

22.51(1) Serial number. Each memory card shall have a serial number printed on a readily visible label. The label shall include the name of the county.

22.51(2) Inventory. Memory cards owned by the county and retained in the custody of the county commissioner shall be maintained under perpetual inventory, with a record of inventory activity. The commissioner shall maintain a similar record of relevant actions if the memory cards are acquired from a vendor for each election. The record of inventory activity shall reflect:

a. The date each memory card was acquired;

b. Each use of each memory card in an election;

Form B (cont'd)

Memory Card Shipping Record for _____ County

Shipped for programming:

Record each card number before packing to ship, and check out each card number on the chain of custody record. Enclose a photocopy of the Memory Card Record with the cards.

Shipped by: _____ Date: ___/___/___ Time: ___:___ a.m./p.m.
Print name Signature

Shipped to: _____ Shipped via: _____
_____ Tracking number: _____

Instructions to vendor:

Check in each card number on the enclosed chain of custody record when unpacking cards.

By: _____ Date: ___/___/___ Time: ___:___ a.m./p.m.
Print name Signature

- If memory cards are removed from this inventory for any reason, make a notation of which card(s) on the Memory Card Record.
- Replacement card(s) if issued should be added to the bottom of the Memory Card Record as a new card. A serial number will be assigned later by the receiving county.

Shipped via: _____ Date: _____ Tracking number: _____

Received by County Election Department on Date: ___/___/___

Was the package sealed? _____ Was the seal intact? _____ Notes: _____

Keep the memory cards in secure storage after they are received and until they are installed in the voting equipment.

22.51(5) Preparation and installation. When memory cards are installed, they shall be sealed immediately into the machine using a numbered, tamper-evident seal. Appropriate log entries shall be completed.

22.51(6) Replacing seals or memory cards. If a seal is accidentally broken or a memory card is replaced for any reason, the issuance of a new seal and the entry into the log shall be witnessed by more than one person. The facts of the incident and the names of the individuals who detected and resolved it shall be recorded.

22.51(7) Opening the polls. Immediately before the polls open on election day, the precinct election officials shall turn on the voting equipment and print the report showing that all counters are set at zero.

22.51(8) Verification log. The commissioner shall provide to each precinct a precinct verification log with the ballot record and receipt. The verification log shall provide places for precinct election officials to record or check the following information before the polls open and again before leaving the polling place at the end of the day:

- Seal numbers from the voting equipment; and
- Condition of seals on ballot containers.

22.51(9) Election day.

a. Before the polls are opened, the precinct election officials shall verify the required information in the verification log and sign the log.

b. After the polls are closed, the precinct election officials shall verify the required information in the verification log and sign the log before leaving the polling place.

c. If the precinct election officials remove the memory cards from the voting equipment, the officials shall first print the results report from the voting equipment.

22.51(10) Return of memory cards. If the precinct election officials remove the memory cards from the voting equipment on election night, they shall return to the commissioner the memory cards and the seals used to secure them in a sealed envelope or other container. All officials of the precinct shall witness the statement on the envelope or other container. The label on the envelope or other container shall be in substantially the following form:

Memory Cards

Election Date: _____

Precinct: _____

This envelope contains Memory Cards and memory card access seals from this precinct.

Machine Number	Memory Card #	Memory Card Seal #

[Signatures of all precinct election officials shall be included on the label.]

22.51(11) Storage. If the memory cards are returned inside the voting equipment to the commissioner, the machine serial numbers and the seal numbers shall be verified against the verification log described in subrule 22.51(8). When the memory cards are removed, their serial numbers shall also be verified against the verification log returned by the precinct's election officials. The memory card audit log shall be retained for the time period required by Iowa Code section 50.19.

22.51(12) Results verified. Before the conclusion of the canvass of votes, the individual results reports from the precincts, as signed by the precinct election officials at the polls on election night, shall be compared to the election results compiled for the canvass (either manually or electronically) to verify that transmitted and accumulated totals match the results witnessed by the election officials. Any discrepancies in these totals shall be reconciled before the supervisors conclude the canvass.

22.51(13) Retention of programmed memory cards. The election information on all memory cards used for an election shall be retained on the memory cards until after the time to file requests for recounts and election contests has passed. If a contest is pending, the memory cards shall be retained until the contest is resolved. Before the memory cards are permanently erased, the commissioner shall print the memory card audit log from each card.

22.51(14) Retention of program information. The commissioner shall retain all instructions and other written records of the process for programming the memory cards and the memory card audit logs for the period required by Iowa Code section 50.19. The contents of memory cards and other electronic records of the election process shall be collected and retained in an electronic or other medium and stored with the other election records for the time period required by Iowa Code section 50.19.

721—22.52(52) Voting equipment malfunction at the polls. The precinct election officials shall immediately cease using any malfunctioning voting equipment and report the problem to the commissioner. Only a person who is authorized in writing by the commissioner to do so shall be

permitted to attempt to repair malfunctioning voting equipment. The person shall show identification to the precinct election official. The commissioner shall keep a written record of all known malfunctions and their resolution. The precinct election officials shall return the voting equipment to service only if the malfunction is corrected.

22.52(1) Routine resolution. Some problems may be easily resolved by following simple instructions. If the commissioner and the precinct election officials are able to resolve a problem without replacing the equipment, the officials shall document the problem, the time it occurred, how it was resolved, and by whom.

22.52(2) Repair or replacement. Repairs to voting equipment at the polls on election day shall be limited. If the problem cannot be easily resolved, a person who is authorized to do so by the commissioner shall replace the equipment as soon as possible. Two election officials, one from each political party, shall witness repair or replacement of any voting equipment, including memory cards. The authorized person making the repair or replacement and the two election officials shall sign a report of the incident.

721—22.53 to 22.99 Reserved.

OPTICAL SCAN VOTING SYSTEMS

721—22.100(52) Optical scan ballots, automatic tabulating equipment, and absentee voting. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.101(52) Definitions. The definitions established by this rule shall apply whenever the terms defined appear in relation to an optical scan system used with the type of ballot defined in this rule.

“Ballot” means the official document that includes all of the offices or public measures to be voted upon at a single election, whether they appear on one or more optical scan ballots.

“Optical scan voting system” means a system employing optical scan ballots under which votes are cast by voters by marking the optical scan ballots with a ballot marking device and thereafter counted by use of automatic tabulating equipment.

“Overvote” means to vote for more than the permitted number of choices for any office or question on a ballot.

“Secrecy envelope” means a reusable envelope of sufficient construction that when the optical scan ballot is inserted in it all portions indicating voting marks are hidden from view.

“Tabulating device” means the portable apparatus which examines and counts the votes recorded on the optical scan ballot and produces a paper printout of the results of the voting.

“Ticket” means each list of candidates nominated by a political party or group of petitioners.

“Undervote” means to vote for fewer than the permitted number of choices for any office or question on a ballot.

“Voting system” means the total combination of mechanical, electromechanical or electronic equipment (including the software, firmware and documentation required to program, control and support the equipment that is used to define ballots, to cast and count votes, to report or display election results and to maintain and produce any audit trail information). “Voting system” also includes the practices and associated documentation used to identify system components and versions of such components, to test the system during its development and maintenance, to maintain records of system errors and defects, to determine specific system changes to be made to a system after the initial qualification of the system and to make available any materials to the voter such as notices, instructions, forms or paper ballots. (See Section 301(b) of HAVA.)

“Voting target” means the space on an optical scan ballot which the voter marks to cast a vote for a candidate, judge or question. This target shall be printed according to the requirements of the voting system to be used to read the ballots.

721—22.102(52) Optical scan ballots. The optical scan ballots shall be printed pursuant to Iowa Code chapters 43 and 49 and by any relevant provisions of any statutes which specify the form of ballots for special elections, so far as possible within the constraints of the physical characteristics of the system.

22.102(1) The optical scan ballots may be printed on both sides of a sheet of paper. If both sides are used, the words “Turn the ballot over” shall be clearly printed on the front and the back of the optical scan ballot, at the bottom.

22.102(2) Printed at the top of the front side of the optical scan ballot shall be the name and date of the election; the words “Official Ballot”; a designation of the ballot style or precinct, if any; and a facsimile of the commissioner’s signature.

22.102(3) The voting target shall be printed opposite each candidate’s name and write-in line on the optical scan ballot, and opposite the “yes” and “no” for each public measure and judge. The voting target shall be printed on the left side of the name or “yes” and “no”. The voting target shall be an oval unless the voting system requires a target with a different shape.

22.102(4) For partisan primary elections, the names of candidates representing each political party shall be printed on separate optical scan ballots. The ballots shall be uniform in quality, texture and size. The name of the political party shall be printed in at least 24-point type (¼" high) at the top of the ballot.

22.102(5) There shall be printed on the ballot a line to accommodate the initials of the precinct election official who endorses the ballot as provided in Iowa Code sections 43.36 and 49.82.

22.102(6) It is not necessary for public measures to be printed on colored paper.

22.102(7) Ballots shall be coded as necessary to allow the tabulation program to identify the appropriate ballots for the precinct. Ballots shall be coded so the tabulating device can identify by precinct the votes cast for each office and question on the ballot by precinct. The votes from the absentee and special voters precinct shall be reported as a single precinct except in general elections pursuant to Iowa Code section 53.20 as amended by 2008 Iowa Acts, House File 2367. Identical ballots shall not be coded to identify groups of voters within a precinct.

22.102(8) No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot. If the full text of a public measure will not fit on a single column of the ballot, the commissioner shall prepare a summary for the ballot and post the full text in the voting booth as required by Iowa Code section 52.25.

22.102(9) Ballots shall be stored in a locked room or storage area. Access to the storage area shall be restricted to those persons identified in the election security plan. Throughout the election process, the commissioner shall keep accurate records of the number of each type of ballot or ballot style printed for the election. This record shall include the number of ballots:

- a. Ordered from the printer.
- b. Printed and delivered by the printer to the commissioner. The commissioner may store sealed, unopened packages of ballots without verifying the number of ballots in the package.
- c. Used for testing as required by Iowa Code sections 52.9 and 52.35 and rule 721—22.41(52).
- d. Held in reserve for emergencies as required by Iowa Code section 49.66.
- e. Delivered to and returned from the polling places as required by Iowa Code sections 49.65 and 50.10.
- f. Used for absentee voting, including any spoiled ballots.
- g. Issued as sample ballots to the public as permitted by Iowa Code section 43.30.
- h. Photocopied ballots used pursuant to Iowa Code section 49.67.
- i. Printed by the commissioner using any voting system program, such as Election Systems & Software’s Ballot on Demand program.

721—22.103 to 22.199 Reserved.

PRECINCT COUNT SYSTEMS

721—22.200(52) Security.

22.200(1) At least one tabulating device shall be provided at each precinct polling place for an election. If the tabulating device is delivered to the polling place before election day, it shall be secured against tampering or kept in a locked room.

22.200(2) The maintenance key or keys used to gain access to the internal parts of the tabulating device shall be kept in a secure place and in a secure manner, in the custody of the commissioner. On election day, the key used to obtain the paper printout shall be kept by the chairperson of the precinct election officials in a secure manner. Small electronic devices, such as memory cards, cartridges or other data storage devices used to activate tabulation equipment or to store election information, shall be in the custody of the precinct chairperson when the devices are not installed on the voting equipment.

22.200(3) If a password is needed for precinct election officials to have routine access to the tabulating device during election day, the password shall be changed for every election. The commissioner shall restrict access to the password in the written security policy.

721—22.201(52) Programming and testing the tabulating devices for precinct count systems.

22.201(1) All programming of tabulating devices shall be performed under the supervision of the commissioner. The devices shall be programmed to ensure that all votes will be counted in accordance with the laws of Iowa. Tabulating devices shall be programmed to return to the voter any ballots:

- a. That are not coded to be used in the precinct.
- b. That are read as blank.
- c. That have one or more overvoted offices or public measures.

22.201(2) Rescinded IAB 10/25/06, effective 10/4/06.

721—22.202 to 22.220 Reserved.

721—22.221(52) Sample ballots and instructions to voters. Sample special paper ballots and printed instructions for casting votes on special paper ballots shall be prominently displayed in each polling place. Instructions shall also be displayed inside each voting booth. Each special paper ballot shall also include an example of the method of marking the ballot recommended by the manufacturer of the tabulating device. Further instructions shall be provided to any voter who requests assistance in accordance with Iowa Code section 49.90.

721—22.222 to 22.230 Reserved.

721—22.231(52) Emergency ballot box or bin. Each precinct shall be furnished with an emergency ballot box or bin that is suitably equipped with a lock and key or numbered, tamperproof seal. In the event of power failure or malfunction of the tabulating device, voted ballots shall be deposited in the locked or sealed emergency ballot box or bin. A precinct election official shall put the ballot into the emergency ballot box or bin for the voter. The voted ballots so deposited may be removed from the locked emergency ballot box or bin and tabulated before the polls close whenever a properly functioning tabulating device becomes available, or the voted ballots so deposited may be removed and counted electronically or manually immediately after the polls are closed. If the ballots are counted manually, the precinct election officials shall follow the requirements of 721—Chapter 26.

721—22.232(52) Manner of voting. After the precinct election official has endorsed a ballot, the official shall instruct the voter to use only the marker provided. The ballot shall be inserted in a secrecy folder and given to the person who is entitled to receive the ballot in accordance with the provisions of Iowa Code section 49.77.

22.232(1) The precinct officials shall provide each voter with a secrecy folder. The commissioner may print basic ballot marking instructions on the secrecy folder. It is not necessary to print information on secrecy folders that will limit the usefulness of the secrecy folder to one or more elections or election types. Upon receipt of the ballot in the secrecy folder, the voter shall retire alone to a voting booth and without delay mark the ballot.

22.232(2) The voter shall vote upon the ballot by marking the appropriate voting target with an appropriate pen or pencil in the manner described in the instructions printed on the ballot.

When a write-in vote has been cast, the ballot must also be marked in the corresponding voting target in order to be counted.

22.232(3) After marking the ballot, the voter shall replace it in the secrecy folder and leave the voting booth at once.

22.232(4) The voter shall at once deposit the ballot, still enclosed in the secrecy folder, in the tabulating device so that the ballot is automatically removed from the secrecy folder, the votes tabulated, and the ballot deposited in the ballot box.

22.232(5) If the tabulating device is equipped with a mechanism that will not permit more than one ballot to be inserted at one time, the voter may insert the ballot into the tabulating device. If the tabulating device cannot detect and reject multiple ballots, the voter shall be required to hand the ballot in the secrecy folder to the precinct election official without revealing any of the marks on the ballot. The precinct election official shall at once deposit the ballot in the manner described in subrule 22.232(4).

22.232(6) If the tabulating device returns a ballot, the precinct official attending the device shall ask the voter to wait. Without examining the ballot, the official shall enclose the returned ballot in a secrecy folder. If necessary, the official shall read to the voter the information provided by the device about the reason the ballot was returned. The official shall offer the voter the opportunity to correct the ballot. The precinct official shall mark the returned ballot “spoiled” and shall also tear or mark the ballot so that the tabulating device cannot count it. The voter may use the spoiled ballot as a guide for marking the corrected ballot. After the voter has marked the corrected ballot, the precinct officials shall collect the spoiled ballot and keep it with other spoiled ballots.

22.232(7) If the voter who cast the returned ballot is not available, or declines to correct the ballot, the precinct official shall not mark the ballot “spoiled.” Either the voter or the official shall reset the tabulating device to accept the ballot. The voter, or the official if the voter has gone, shall insert the ballot into the precinct counter without further examination.

721—22.233 to 22.239 Reserved.

721—22.240(52) Results. After the polls are closed and the tabulating device has processed all of the ballots, including any ballots from the emergency ballot box or bin, the precinct election officials shall:

22.240(1) Unlock the tabulating device and obtain a paper printout showing the votes cast for each candidate and public measure.

22.240(2) Fasten the paper printout to the official tally sheet.

22.240(3) Unlock or remove the seal on the ballot box or bin containing ballots with write-in votes and open it. The precinct officials shall remove the ballots and manually count the write-in votes as required by 721—Chapter 26. The officials shall record the write-in votes in the tally list. A single tally list is sufficient for use when tabulating write-in votes.

22.240(4) Seal all ballots in a transfer case to be returned to the commissioner in accordance with Iowa Code section 50.12.

22.240(5) It is not necessary for the precinct officials to separate primary election ballots by political party.

721—22.241(52) Electronic transmission of election results. If the equipment includes a modem for the electronic transmission of election results, the precinct officials may transmit the results after a printed copy has been made. If the voting system includes a data card, cartridge or other small device that contains an electronic copy of the election results, the precinct chairperson shall secure the device and ensure its safe delivery to the commissioner.

721—22.242 to 22.249 Reserved.

721—22.250(52) Absentee voting instructions. Printed instructions shall be included with the ballot or ballots given to or mailed to each absentee voter. Written instructions to the voter shall be sent with every absentee ballot. For federal elections, the commissioner shall use only the instructions provided by the state commissioner.

721—22.251(52) Absentee voting instructions. Rescinded IAB 11/23/05, effective 12/28/05.

721—22.252 to 22.259 Reserved.

721—22.260(52) Specific precinct count systems. Additional rules are provided for the following systems approved for use in Iowa. Rule 721—22.261(52) applies only to the voting system indicated and is in addition to the general provisions set forth in rules 721—22.200(52) through 721—22.250(52).

721—22.261(52) Election Systems & Software Model 100—preparation and use in elections.

22.261(1) Security. The commissioner shall have a written security plan for the voting system. Access to equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at the polling places on election day shall be changed for each election.

b. The control key for the Model 100 shall be in the possession of the precinct chairperson during election day.

22.261(2) Configuration choices. The following selections are mandatory for all elections:

a. *Maximum number of votes.* The following description for each office shall be used: “Vote for no more than xx.” Do not include “vote for” language for public measures or judges.

b. *Ballot control.* In an official election, the commissioner shall never program the Model 100 for unconditional acceptance of all ballots; shall not divert blank ballots to the write-in bin; and shall always accept undervoted ballots. The system shall be programmed to query the voter in each of the following situations:

(1) Overvoted ballot.

(2) Blank ballot.

(3) Unreadable ballot.

c. *Unit control.* The commissioner shall not select automatic transmission of election results by modem. The precinct officials must print the official results at the polling place before transmitting them.

d. *Reports.* The following are required reports:

(1) Opening the polls. Print the Zero Certification report.

(2) Closing the polls. Print the poll report before transmitting the election results by modem. The poll report is the official record of the votes cast in the precinct on election day.

(3) Certification text to appear at the end of the poll report:

We, the undersigned Precinct Election Officials of this precinct, hereby attest that this tape shows the results of all ballots cast and counted by the M100 Optical Scan tabulation device at this election.

[print lines for each of the officials to sign]

Precinct Election Officials Date: _____ Time: _____

e. *Reopen polls.* The commissioner shall enable this option, but protect it against unauthorized use. If it is necessary to reopen the polls, the chairperson of the precinct board shall contact the commissioner for the password.

22.261(3) Ballot printing.

a. *Format.* The office title, instructions about the maximum number of choices the voter can make for the office, the candidate names and all write-in lines associated with each office on the ballot shall be printed in a single column on the same side of the ballot. All text and the “yes” and “no” choices for each public measure and for each individual judge on a ballot shall be printed in a single column on the same side of the ballot. No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot.

b. *Instructions for voters.* The following instructions shall be printed on ballots:

(1) Voting mark. To vote, fill in the oval next to your choice.

 CANDIDATE NAME
 CANDIDATE NAME

(2) Straight party voting. To vote for all candidates from a single party, fill in the oval in front of the party name. Not all parties have nominated candidates for all offices. Marking a straight party vote does not include votes for nonpartisan offices, judges or questions.

(3) Public measures.

Notice to voters. To vote to approve any question on this ballot, fill in the oval in front of the word “Yes”. To vote against a question, fill in the oval in front of the word “No”.

22.261(4) System error messages. Precinct election officials shall be provided with the following list of system error messages and the appropriate responses. The officials shall be instructed to contact the commissioner or the commissioner’s designee for all other messages.

Overvoted ballot returned. Ask voter to reinsert ballot. If the ballot is returned again, do not look at the voter’s ballot. Put it in a secrecy folder. Tell the voter that for one or more offices the scanner read more votes than the maximum number of votes allowed. To correct the error, the voter must mark a new ballot and may copy votes from the original ballot. Only if the voter agrees to mark a new ballot, write “spoiled” on the original ballot and tear off one corner to prevent it from being accepted by the scanner. Advise the voter to return to the booth and mark the new ballot. Be sure to collect the spoiled ballot before the voter leaves.

Overvoted ballot accepted. This message will appear when the scanner accepts an overvoted ballot.

Unidentified mark—check your ballot. One or more marks on the ballot are not dark enough to be seen as a vote. Do not look at the voter’s ballot. Put it in a secrecy folder and return the ballot to the voter. Ask the voter to review the ballot and to darken the marks. Then the voter may put the ballot back into the scanner.

If any of the following messages appear more than twice for the same ballot, call the auditor’s office to report the problem:

100—MISSED ORIENTATION MARKS/Turn Ballot Over and Try Again.

101—MISSED TIMING MARKS/Turn Ballot Over and Try Again.

102—NO DATA FOUND/Please Reinsert Ballot After Beeps.

104—ORIENTATION SKIP ERROR.

106—MISSED TIMING MARKS/Turn Ballot Over and Try Again.

If any of the following messages appear, ask the voter to remove the ballot and reinsert it. If the same message appears more than twice for the same ballot, call the auditor’s office to report the problem.

107—BALLOT ERROR: INVALID CC SEQUENCE.

108—BALLOT ERROR: INVALID CC TYPE.

109—BALLOT ERROR: INVALID CC SPLIT.

115—MISSED BACK ORIENTATION MARK/Turn Ballot Over and Try Again.

119—MULTIPLE BALLOTS DETECTED/Please Reinsert Ballot After Beeps. Did the voter actually try to put an extra ballot in? Is the ballot folded?

123—UNABLE TO READ TIMING BAND/Turn Ballot Over and Try Again.

124—BALLOT DRAGGED/Turn Ballot Over and Try Again.

126—BLACK CHECK: FACE DOWN HEAD EDGE/Turn Ballot Over and Try Again.

127—BLACK CHECK: FACE DOWN TAIL EDGE/Turn Ballot Over and Try Again.

128—BLACK CHECK: FACE UP HEAD EDGE/Turn Ballot Over and Try Again.

129—BLACK CHECK: FACE UP TAIL EDGE/Turn Ballot Over and Try Again.

130—POSSIBLE FOLDED BALLOT/Turn Ballot Over and Try Again.

22.261(5) Record retention. The Model 100 uses a thermal printer. The maximum anticipated life span of the results from each Model 100 is only five years. In order to preserve the permanent record of the precinct results required by Iowa Code section 50.19, the commissioner shall print a copy of the results of each precinct on permanent paper and store these copies with the tally lists from precincts where the Model 100 was used.

[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.262(52) Premier Election Solutions' AccuVote OS and AccuVote OSX precinct count devices.

22.262(1) Security. The commissioner shall have a written security plan for the voting system. Access to voting equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

- a. Passwords used at polling places shall be changed for each election.
- b. For each election, the precinct chairperson shall be responsible for the custody and security of the control card and ballot box keys and the security of the voting system.

22.262(2) Configuration choices. The following selections are mandatory for all elections:

- a. Reject settings shall be configured as follows:
 - (1) Return to voters ballots that include one or more overvoted races and blank-voted ballots. Include on the override log the number of times the override option was used for overvoted and blank-voted ballots.

- (2) Divert to the write-in ballot bin only ballots with write-in votes.

- (3) Do not include reject settings for blank voted races, undervoted races, straight party overvotes, multiparty overvotes or duplicate votes.

- b. Tally settings shall be as follows:

- (1) The straight party shall be “Exclusive.”

- (2) The write-in setting shall be “Combined.”

22.262(3) Zero totals reports. Long form zero totals reports showing all counters at zero shall be printed following memory card programming, before counting ballots in the Pre-Election Mode and as the ballot reader is opened on election day.

22.262(4) Ballot printing. Although the Premier Election Solutions' GEMS voting system software includes choices for variations in ballot layout, all ballots shall be prepared according to the requirements of Iowa Code sections 43.26 through 43.29 and 49.30 through 49.48. For all elections the voting target shall be an oval printed on the left side of each choice on the ballot.

22.262(5) Preelection testing. All voting equipment shall be tested pursuant to the provisions of Iowa Code section 52.30 and rule 721—22.42(52). At the commissioner’s discretion, the commissioner may conduct additional tests.

721—22.263(52) AutoMARK Voter Assist Terminal (VAT).

22.263(1) Acceptance testing. Upon receipt of the equipment from the vendor, the commissioner shall subject each AutoMARK VAT to an acceptance test. The test shall be in addition to any testing provided by the vendor and shall include a demonstration of all functionalities of the device.

22.263(2) Audio ballot preparation. Each candidate shall have the opportunity to provide a record of the proper pronunciation of the candidate’s name. The same voice shall be used for recording the entire ballot including instructions, office titles, candidate names and the full text of all public measures.

22.263(3) Preelection testing. Each AutoMARK VAT shall be tested before each election in which it will be used. The commissioner may use the AutoMARK VAT to prepare some ballots for test decks required by rule 721—22.42(52). In addition, the commissioner shall:

- a. Perform the test ballot print, then review the ballot to be sure that all ovals are darkened and the appropriate names are printed on each line.

- b. Calibrate the touchscreen.

- c. Select, then deselect each voting position in each race.

- d. Verify that the overvote and undervote functions are programmed correctly.

- e. Test the write-in function for each office on one ballot, and test all of the letters in the alphabet.

- f. Use the audio ballot function to mark one ballot.

- g. Tabulate the marked ballots from this test on the appropriate optical scanner.

- h. Ensure that the AutoMARK VAT is available for demonstration at public tests.

22.263(4) Compact flash memory cartridge or memory card. The compact flash memory cartridge shall be installed before the AutoMARK VAT is locked, sealed and shipped to the polling place for election day. In addition to locking the memory cartridge access door, the commissioner shall seal the door with a numbered seal, record the seal number, and provide the number to the precinct election officials as required by rule 721—22.51(52). From the time the AutoMARK VAT is delivered to the polling place until the time the precinct election officials arrive, the AutoMARK VAT shall be stored securely to prevent tampering. On election day, the precinct election officials shall inspect the seal and verify that the original numbered seal is present and undamaged.

22.263(5) Calibration testing. The commissioner may provide for printer and touchscreen calibration testing after delivery of the AutoMARK VAT to the polling place. If calibration testing is performed at the polling place, the delivery staff shall complete the testing before the polls open on election day and shall keep a log for each AutoMARK VAT and record the machine serial number, the precinct name or number, the date and time of the test, the name of the person performing the test, and the lifetime printer counter number at the completion of the test. The ballot to be used in the calibration test shall be provided to the tester and shall be labeled with the precinct name and election date. The completed calibration test ballot shall be returned to the commissioner and kept with the election records.

22.263(6) AutoMARK VAT keys. Possession of the AutoMARK VAT keys shall be restricted to precinct election officials and authorized members of the commissioner's staff.

22.263(7) Table. The table used to support the AutoMARK VAT shall meet the following requirements: The table shall be sturdy enough to hold the 40-pound AutoMARK VAT safely. Clearance shall be at least 27 inches high, 30 inches wide, and 26 inches deep. The top of the table shall be from 28 inches to 34 inches above the floor.

22.263(8) Privacy. The commissioner may provide each AutoMARK VAT with a privacy shield to protect the secrecy of each voter's ballot. The commissioner shall instruct the precinct election officials to position the AutoMARK VAT to provide maximum access for voters (especially voters who use wheelchairs) as well as privacy.

22.263(9) Abandoned ballots. If a voter or precinct election official discovers that a voter has left the AutoMARK VAT without printing the voter's ballot, the two precinct election officials designated to assist voters shall print the ballot without reviewing the ballot or making any changes, enclose the ballot in a secrecy folder, and immediately deposit the ballot in the tabulating device.

721—22.264 to 22.339 Reserved.

OPTICAL SCAN VOTING SYSTEM USED FOR ABSENTEE AND SPECIAL VOTERS PRECINCT

721—22.340(52) Processing. All scanners used to tabulate absentee and provisional ballots shall be configured to sort blank ballots and ballots containing marks in write-in vote targets for review by the resolution board. The scanners shall not be configured to sort ballots with overvotes. However, if it is not possible to configure the scanners used to count absentee ballots differently from those used at the polling places, the person operating the scanner shall override the scanner and accept overvoted ballots as they are processed. The resolution board shall follow the requirements of 721—subrule 26.2(2). The commissioner shall provide the resolution board with a copy of 721—Chapter 26, "Counting Votes."

This rule is intended to implement Iowa Code section 52.33 as amended by 2007 Iowa Acts, Senate File 369, section 9.

721—22.341(52) Reporting results from absentee ballots and provisional ballots. Absentee and provisional ballot results shall be reported as a single precinct as required by subrule 22.102(7).

721—22.342(52) Tally list for absentee and special voters precinct.

22.342(1) Write-in votes shall be reported on a separate tally sheet which provides a column for the names of offices, a column for the names of persons receiving votes, space to tally the votes received, and a column in which to report the total number of votes cast for each person. In tally lists provided for primary elections, separate pages shall be provided to tally the write-in votes for each political party. Each member of the board who participated in the count shall attest to each tally sheet for write-in votes.

22.342(2) The officials shall certify the procedures followed. The certification shall be in substantially the following form:

Absentee and Special Voters Tally Certificate

_____ County

We, the undersigned officials of the Absentee and Special Voters Precinct for this county, do hereby certify that all ballots delivered to the Board for this election were tabulated as shown in the attached report.

We further certify that a record of any write-in votes or other votes manually counted pursuant to Iowa Code chapter 52 is included in this Tally List, and that the numbers entered in the column headed "Total Votes" are the correct totals of all votes manually counted by us.

Signed at _____ on ___/___/___, ___:___ a.m./p.m.

[signatures of officials] 1. _____
2. _____ (etc.)

22.342(3) The record generated by the tabulating equipment shall be attached to or enclosed with the tally list and shall constitute the official return of the precinct.

This rule is intended to implement Iowa Code section 52.33 as amended by 2007 Iowa Acts, Senate File 369, section 9.

721—22.343(39A,53) Counting absentee ballots on the day before the general election. When absentee ballots are tabulated on the day before the election as permitted or required by Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670, the absentee and special voters precinct board and county commissioner shall implement the following security precautions:

22.343(1) *Seal and label voted ballot envelopes or other containers with date of tabulation.* The precinct election officials shall seal all ballots tabulated on the day before the election in a voted ballot envelope or other container labeled with the date of tabulation. The precinct election officials shall seal and sign the envelope or other container in a manner that will make it evident if the envelope or other container is opened.

22.343(2) *Ensure secure storage of all ballots.* Before adjourning for the day, the precinct election officials shall transfer custody of all absentee ballots to the commissioner. The commissioner shall ensure all absentee ballots are stored in a secure location until tabulation is resumed on election day.

22.343(3) *Ensure memory card security.* Before the absentee and special voters precinct board adjourns for the day, the memory card used in the tabulator(s) on the day before the election shall be secured by the precinct election officials in one of the following ways:

a. The memory card may be left in the tabulator when a tamper-evident seal is affixed over the memory card in a manner that will make it evident if the seal is removed.

b. The memory card may be removed from the tabulator and placed in an envelope. The precinct election officials shall seal the envelope in a manner that will make it evident if the envelope is opened.

22.343(4) *Ensure security of the tabulator(s).* Before adjourning for the day, the precinct election officials shall ensure the security of the tabulator(s). The tabulator(s) must be stored in a secure location until the absentee and special voters precinct board resumes tabulation on election day.

22.343(5) *No results tape printing on the day before the election.* No results tapes may be printed from the tabulator(s) on the day before the election.

22.343(6) *No upload of results to tabulating software until election day.* No results may be uploaded or input into tabulating software on the day before the election.

22.343(7) *Verify no tampering before resuming tabulation on election day.* Before tabulation resumes on election day, the absentee and special voters precinct board shall verify the tabulator(s), memory card(s) and memory card port(s) have not been obviously tampered with overnight.

22.343(8) *Resume tabulation.* The absentee and special voters precinct board shall resume tabulation using one of the following methods:

a. Using the same memory card(s) used on the day before the election and resuming tabulation.

b. Using a new memory card(s) and compiling the results contained on the memory card(s) used on election day and on the day before the election.

22.343(9) *Print audit logs.* After the election, the audit logs must be printed and be available for public inspection.

This rule is intended to implement Iowa Code section 39A.5, section 1, paragraph “a,” subparagraph (3), and Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.
[ARC 8698B, IAB 4/21/10, effective 6/15/10]

721—22.344 to 22.349 Reserved.

721—22.350(52) Election Systems & Software models. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.351(52) Diebold Election Systems’ AccuVote-OS central count process. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.352 to 22.430 Reserved.

VOTING MACHINES

721—22.431(52) Temporary use of printed ballots in voting machine precincts. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.432(52) Abandoned ballots. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.433(52) Prohibited uses for direct recording electronic voting machines. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.434(52) Audio ballot preparation. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.435 to 22.460 Reserved.

721—22.461(52) MicroVote Absentee Voting System. Rescinded IAB 8/1/07, effective 7/13/07.

721—22.462(52) Fidler & Chambers’ Absentee Voting System. Rescinded IAB 10/30/02, effective 1/1/03.

721—22.463(52) Election Systems & Software iVotronic. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.464(52) Diebold Election Systems AccuVote TSX DRE. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.465 to 22.499 Reserved.

721—22.500(52) Blended systems. Rescinded IAB 10/8/08, effective 9/19/08.

These rules are intended to implement Iowa Code chapter 52.

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[Filed ARC 9468B (Notice ARC 9292B, IAB 12/29/10), IAB 4/20/11, effective 5/25/11]

CHAPTER 26
COUNTING VOTES

PART I—GENERAL PROVISIONS

721—26.1(49) Definitions.

“*Blank ballot*” means a ballot that contains no votes that can be detected by a tabulating device. See also “*unvoted ballot*.”

“*Hesitation mark*” means a small mark made by resting a pen or pencil on the ballot.

“*Optical scan voting system*” includes a tabulating device that reads ballots by detecting voters’ marks using reflected or absorbed light. An optical scan voting system may be used to count ballots either at the polling place (precinct count) or at a counting center (central count). Optical scan ballots are special paper ballots designed for use with an optical scan voting system.

“*Overvote*” means to vote for more than the permitted number of choices for any office or question on a ballot.

“*Paper ballot*” as used in this chapter means a ballot that is intended to be counted only after inspection by precinct election officials. “*Paper ballot*” in this context means a ballot provided at a precinct that does not have optical scan voting equipment.

“*Prescribed mark*” means the mark shown in the voting instructions as the appropriate way to mark a vote. “*Prescribed mark*” includes a close approximation of the mark.

“*Question*” as used in this chapter includes a public measure as defined by Iowa Code section 39.3(10) and a judicial retention question pursuant to Iowa Code section 46.21.

“*Random mark*” means a mark on a ballot (other than the prescribed mark) that is used inconsistently, either in or near the voting target or the names of candidates.

“*Straight party vote*” means a vote cast in the area of the ballot where political parties and nonparty political organizations are listed, pursuant to Iowa Code section 49.37(1).

“*Stray mark*” means a mark on a ballot that appears to be accidental or appears to be unrelated to the act of filling in the voting target.

“*Tabulating device*” means the portable apparatus that removes the special paper ballot from the secrecy envelope, examines and counts the votes recorded on the special paper ballot, and produces a paper printout of the results of the voting.

“*Undervote*” means to vote for fewer than the permitted number of choices for any office or question on a ballot.

“*Unvoted ballot*” means a ballot that has not been marked in any way. See also “*blank ballot*.”

“*Vote*” means the voter’s choice for an office or question on the ballot.

“*Voting target*” means the place designated on a ballot for the voter to mark the voter’s choice.

“*Write-in vote*” means a vote cast pursuant to Iowa Code section 49.99 or 52.16.

[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—26.2(49) Counting votes on election day.

26.2(1) *Optical scan—precinct count.* Ballots shall be counted at the polling place on election day using the equipment provided. The precinct election officials shall not examine ballots accepted and counted by the tabulating device. After the polls close, the precinct election officials shall:

- a. Remove any ballots from the emergency ballot box and insert them into the tabulating device.
- b. Examine ballots sorted by the tabulating device because they contain write-in votes and count the write-in votes following the standards in rule 26.20(49).
- c. Examine ballots rejected by the tabulating device and abandoned by the voter only if the tabulating device has no override device that permits the officials to reset the tabulating device to accept blank or overvoted ballots. The officials shall follow the standards in rules 26.12(50) through 26.21(49).

26.2(2) *Optical scan—absentee and special voters precinct.* The ballots shall be counted at a single location on election day as required by Iowa Code section 53.23. When it is necessary to duplicate or

enhance a ballot because it is read as blank, the officials shall follow the standards in rules 26.12(50) through 26.21(49).

26.2(3) Paper ballots. Ballots shall be counted at the polling place on election day as provided in Iowa Code chapter 50 or 51, as applicable, according to the standards in Part III.
[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—26.3(50) Reporting overvotes and undervotes. The reports from computerized voting equipment and canvass summaries for precinct, county and state canvasses of votes shall include the number of overvotes and undervotes for each office and question on the ballot. Undervotes and overvotes shall not be reported on abstracts of votes prepared pursuant to Iowa Code sections 50.24 and 50.39.

EXAMPLE: For a special election, 100 people voted using an optical scan voting system. The printed report from the machine tally of votes should be in substantially the following form:

Number of voters = 100

City Official

Candidate 1	24
Candidate 2	51
Candidate 3	12
Write-in votes	8
Overvotes	2
Undervotes	3

The vote tally portion of the abstract of votes for this office would read as follows:

For the office of city official, there were ninety-five (95) votes cast as follows:

Candidate 1 received twenty-four (24) votes.

Candidate 2 received fifty-one (51) votes.

Candidate 3 received twelve (12) votes.

Scattering received eight (8) votes.

721—26.4(50) Absentee and special voters precinct. The absentee and special voters precinct board shall tabulate ballots in the manner appropriate to the voting equipment, if any has been provided. When an optical scan voting system is used, the board shall follow the procedures in subrule 26.2(2).
[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—26.5 to 26.9 Reserved.

PART II—OPTICAL SCAN VOTING SYSTEMS

721—26.10(50) Systems affected. The following rules apply to all optical scan voting systems in use in Iowa.

721—26.11(50) Examples used. The examples used in this part all show the voting target as an oval on the left-hand side next to each candidate's name. The same principles demonstrated in the examples apply to other types of voting targets on optical scan ballots.

721—26.12(50) Wrong ballots. Optical scan voting equipment shall be programmed to reject ballots not coded for use in the precinct, as required by 721—subrule 22.201(1). If a recount board appointed pursuant to Iowa Code section 50.48 finds ballots that are coded for a precinct other than the precinct being tabulated, those ballots shall not be counted unless the commissioner or the commissioner's designee reports that the wrong ballots were delivered to the polling place. The recount board shall immediately report to the commissioner the number of these ballots. The recount board and the commissioner shall securely seal the ballots coded for another precinct and attach to the ballot package

a report of the findings. A copy of the report shall be forwarded to the county attorney as a possible violation of Iowa Code section 39A.2(1) “b”(2).

721—26.13(50) Ballot properly marked by the voter. No ballot properly marked by the voter shall be rejected:

1. Because of any discrepancy between the printed ballot and the nomination paper, or certificate of nomination, or certified abstract of the canvassing board.
2. Because of any error in stamping or writing the endorsement thereon by the officials charged with such duties.
3. Because of any error on the part of the officer charged with such duty in delivering the wrong ballots at any polling place.

721—26.14(50) Ballots with identifying marks. The precinct election officials shall reject a ballot if the ballot includes an identifying mark. The following marks shall be considered to be identifying marks:

1. A comment or statement that indicates the identity of the voter either individually or as a member of a group.
 2. Initials, a printed name or a signature placed on the ballot in any place other than on the lines intended for write-in votes or intended for the initials of the election official who issued the ballot.
- If the ballot has an identifying mark, the precinct election officials shall mark the ballot “Defective due to identifying mark.” The precinct officials in precincts where optical scan voting equipment is used shall tally the votes on all ballots with identifying marks. All of the precinct election officials shall sign the tally. They shall include the tally of ballots with identifying marks in the tally list. The officials shall return the ballots with identifying marks to the commissioner in the envelope or container for disputed ballots as required by Iowa Code section 50.5.

721—26.15(49) Voter’s choice. A vote for any office or question on a ballot shall not be rejected solely because a voter failed to follow instructions for marking the ballot.

26.15(1) If the choice of the voter is clear from the marks for any office or question, the vote shall be counted as the voter has indicated.

26.15(2) If for any reason it is impossible to determine the choice of the voter for any office or question, the vote for that office or question shall not be counted.

721—26.16(49) Determination of voter’s choice.

26.16(1) If a voter uses both the prescribed mark and other marks, only the prescribed marks shall be counted as votes.

EXAMPLE: The voter has used both the prescribed mark and a cross in the voting targets within the same office.

For Board of Supervisors

(Vote for no more than two.)

- | | |
|---|-------------------------|
|  | CANDIDATE 1 (Party A) |
|  | CANDIDATE 2 (Party A) |
|  | CANDIDATE 3 (Party B) |
|  | CANDIDATE 4 (Party B) |
|  | _____ |
| | (Write-in vote, if any) |
|  | _____ |
| | (Write-in vote, if any) |

This example shows a vote for CANDIDATE 4. It is not clear from the voter’s mark whether the mark in the oval for CANDIDATE 3 is intended as a vote.

26.16(2) If a voter does not use the mark prescribed in the voting instructions but consistently uses some other mark, the mark shall be counted as a vote if the mark is:

- a. In the voting target, or

b. In close proximity to a candidate’s name or to a voting target associated with a candidate’s name or with a “yes” or “no” choice for a ballot question.

721—26.17(49) Marks not counted. The following marks on ballots shall not count as votes:

- | | | |
|---|----------|---|
| 1. Hesitation marks. | Example: |  |
| 2. Identifying marks. | Example: |  |
| 3. Random marks.
(Marks for which there is no consistent pattern.) | Example: |  |
| 4. Stray marks. | Example: |  |

721—26.18(49) Acceptable marks. If the voter uses or places marks on the ballot in a consistent manner as described in subrule 26.16(2), the marks shall be counted as votes. The following marks shall count as votes:

- The prescribed mark as shown in the voting instructions as the correct manner of marking a vote.
- A mark that is a close approximation of the prescribed mark but that strays outside the voting target or does not completely fill the voting target. (See Example A of this rule.)
- Any mark inside the voting target if the mark is consistently used instead of the prescribed mark. This includes a cross, check mark, asterisk, plus sign, diagonal, horizontal, or vertical line or any mark that is substantially contained within the voting target. (See Example B of this rule.)
- Any mark of the type described in “3” above that is near the name of a candidate or voting target. (See Examples C and D of this rule.)
- A circle around the voting target for all choices. (See Example E of this rule.)
- A circle around or a line drawn under the name of the candidate for all choices. (See Example F of this rule.)
- Names of candidates not crossed out, if the voter has crossed out the names of all candidates except the number (or fewer) to be elected for each office. (See Example G of this rule.)

EXAMPLE A: Close approximations. The voter has consistently marked the ballot by scribbling in the voting targets. The marks do not completely blacken the voting target and one mark strays outside the voting target.

For Board of Supervisors

(Vote for no more than two.)

- | | |
|---|-------------------------|
|  | CANDIDATE 1 (Party A) |
|  | CANDIDATE 2 (Party A) |
|  | CANDIDATE 3 (Party B) |
|  | CANDIDATE 4 (Party B) |
|  | _____ |
| | (Write-in vote, if any) |
|  | _____ |
| | (Write-in vote, if any) |

This example shows a vote for CANDIDATE 3 and a vote for CANDIDATE 4. The same principle applies for other voting marks. If the mark used is a close approximation of the prescribed mark, it shall be counted as a vote provided that all other applicable standards are met.

EXAMPLE B: Acceptable mark in the voting target. The voter has consistently marked each choice by putting a check mark in the voting target.

For Board of Supervisors
 (Vote for no more than two.)

<input type="radio"/>	CANDIDATE 1 (Party A)
<input type="radio"/>	CANDIDATE 2 (Party A)
<input checked="" type="radio"/>	CANDIDATE 3 (Party B)
<input type="radio"/>	CANDIDATE 4 (Party B)
<input type="radio"/>	_____
	(Write-in vote, if any)
<input checked="" type="radio"/>	<u>Martha Stone</u>
	(Write-in vote, if any)

This example shows a vote for CANDIDATE 3 and a vote for the write-in choice, Martha Stone.

EXAMPLE C: Acceptable mark placed near the voting target. The voter has consistently marked each choice by putting a check mark in the space between the voting target and the candidate's name.

For Board of Supervisors
 (Vote for no more than two.)

<input type="radio"/>	CANDIDATE 1 (Party A)
<input checked="" type="radio"/>	CANDIDATE 2 (Party A)
<input checked="" type="radio"/>	CANDIDATE 3 (Party B)
<input type="radio"/>	CANDIDATE 4 (Party B)
<input type="radio"/>	_____
	(Write-in vote, if any)
<input type="radio"/>	_____
	(Write-in vote, if any)

This example shows a vote for CANDIDATE 2 and a vote for CANDIDATE 3.

EXAMPLE D: Acceptable mark placed near a candidate's name. The voter has consistently marked each choice by putting a check mark behind the candidate's name.

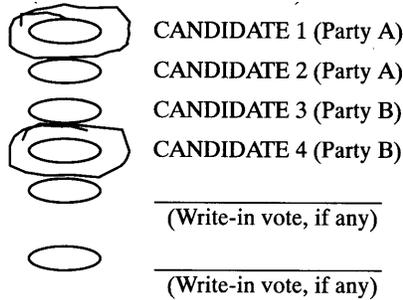
For Board of Supervisors
 (Vote for no more than two.)

<input checked="" type="radio"/>	CANDIDATE 1 (Party A)
<input type="radio"/>	CANDIDATE 2 (Party A)
<input type="radio"/>	CANDIDATE 3 (Party B)
<input checked="" type="radio"/>	CANDIDATE 4 (Party B)
<input type="radio"/>	_____
	(Write-in vote, if any)
<input type="radio"/>	_____
	(Write-in vote, if any)

This example shows a vote for CANDIDATE 1 and a vote for CANDIDATE 4.

EXAMPLE E: Choices circled. The voter has consistently marked each choice by circling the voting target.

For Board of Supervisors
 (Vote for no more than two.)

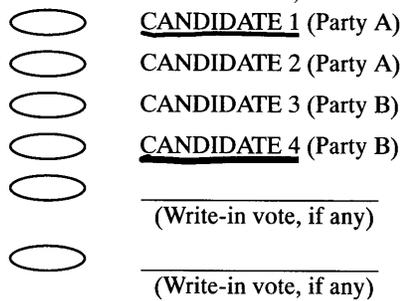


This example shows a vote for CANDIDATE 1 and a vote for CANDIDATE 4.

EXAMPLE F: Choices underlined. The voter has consistently marked each choice by underlining the name of the candidate.

For Board of Supervisors

(Vote for no more than two.)

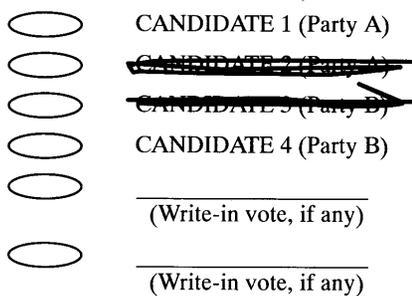


This example shows a vote for CANDIDATE 1 and a vote for CANDIDATE 4.

EXAMPLE G: Choices not crossed out. The voter has consistently marked each choice by crossing out the names of candidates not chosen.

For Board of Supervisors

(Vote for no more than two.)



This example shows a vote for CANDIDATE 1 and a vote for CANDIDATE 4.

721—26.19(49) Counting straight party or organization votes. Precinct count and central count tabulating devices shall be programmed to count straight party votes according to this rule. Precinct election officials and recount boards shall count straight party votes according to this rule.

26.19(1) When a voter has marked a voting target for one political party or one nonparty political organization, each candidate on the ballot for that party or organization shall receive one vote.

26.19(2) Overvote. If a voter has marked the voting target next to the name of more than one political party or organization, only votes cast for individual candidates shall be counted.

26.19(3) Overriding a straight party vote. If the voter has marked a straight party vote and has also marked a voting target for a candidate or for a write-in line for a partisan office, the straight party vote shall not apply to that office. The vote shall be counted as the voter has marked that individual office.

26.19(4) More than one candidate to be elected. If the voter may vote for more than one candidate for an office, a straight party vote does not apply to that office if the voter marks one or more voting targets next to the names of candidates listed under that office title or if the voter marks one or more voting targets next to write-in lines. The vote shall be counted as the voter has marked that individual office.

EXAMPLE for 26.19(2): Straight party overvote. The voter has marked a straight party vote for Party A and for Organization D.

STRAIGHT PARTY VOTING

- POLITICAL PARTY A
- POLITICAL PARTY B
- POLITICAL ORGANIZATION C
- POLITICAL ORGANIZATION D

This example shows an overvote. Count only votes cast separately for candidates listed on the ballot.

EXAMPLE A for 26.19(3) and 26.19(4): Overriding a straight party vote. The voter has marked a straight party vote for Party A. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- _____
(Write-in vote, if any)
- _____
(Write-in vote, if any)

This example shows a vote for CANDIDATE 4. No votes shall be counted for either of the two candidates from Party A. The vote for CANDIDATE 4 overrides the straight party vote.

EXAMPLE B for 26.19(3) and 26.19(4): Overriding a straight party vote. The voter has marked a straight party vote for Party A. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- _____
(Write-in vote, if any)
- _____
(Write-in vote, if any)

This example shows a vote for CANDIDATE 2. No vote shall be counted for CANDIDATE 1, who is also a candidate for Party A. The separate vote for one candidate of Party A overrides the straight party vote.

EXAMPLE C for 26.19(3) and 26.19(4): Overriding a straight party vote. The voter has marked a straight party vote for Party A. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

<input type="radio"/>	CANDIDATE 1 (Party A)
<input type="radio"/>	CANDIDATE 2 (Party A)
<input type="radio"/>	CANDIDATE 3 (Party B)
<input type="radio"/>	CANDIDATE 4 (Party B)
<input checked="" type="radio"/>	<hr/> (Write-in vote, if any)
<input type="radio"/>	<hr/> (Write-in vote, if any)

This example shows a vote for “blank.” No vote shall be counted for either of the two Party A candidates: CANDIDATE 1 or CANDIDATE 2. The separate vote for a write-in choice overrides the straight party vote.

EXAMPLE D for 26.19(3), 26.19(4) and 26.20(3): Overriding a straight party vote. The voter has marked a straight party vote for Party A. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

<input type="radio"/>	CANDIDATE 1 (Party A)
<input type="radio"/>	CANDIDATE 2 (Party A)
<input type="radio"/>	CANDIDATE 3 (Party B)
<input type="radio"/>	CANDIDATE 4 (Party B)
<input checked="" type="radio"/>	<hr/> <i>Candidate 1</i> (Write-in vote, if any)
<input checked="" type="radio"/>	<hr/> <i>Candidate 2</i> (Write-in vote, if any)

This example shows a vote for CANDIDATE 1 and a vote for CANDIDATE 2. Although the write-in vote duplicates the voter’s straight party vote, it is clear that the voter has chosen CANDIDATE 1 and CANDIDATE 2. The precinct election officials shall include one vote for CANDIDATE 1 and one vote for CANDIDATE 2 in the write-in tally.

721—26.20(49) Write-in votes.

26.20(1) The precinct election officials and recount board members shall count a write-in vote only if the voting target is marked.

26.20(2) If a voter writes the name of the same person more than once in the proper places on a ballot for an office to which more than one person is to be elected, all but one of those votes for that person for that office are void and shall not be counted.

26.20(3) If a write-in vote duplicates an otherwise correctly cast vote for a candidate whose name appears on the ballot, the write-in vote shall be counted. The ballot has been read as overvoted for this office, and all other votes have been counted by the tabulator.

26.20(4) Write-in votes cast for the office of president and vice president, or for governor and lieutenant governor, shall be tabulated as a single vote for a pair of candidates.

26.20(5) Names. The officials tabulating write-in votes shall disregard misspellings or variations in names or abbreviations for write-in candidates and shall count the variations in the form of the name for a single person if the officials can determine for whom the write-in votes were cast. Write-in votes for fictitious characters shall be tabulated as written.

EXAMPLE A for 26.20(1): Write-in voting target not marked. The voter has not marked the voting target for the write-in votes. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- Candidate 1
(Write-in vote, if any)
- Candidate 2
(Write-in vote, if any)

This example does not show a vote. Iowa Code section 49.99 requires voters to mark the voting target for write-in votes on optical scan ballots. If the voting target for a write-in vote is not marked, the vote does not count.

EXAMPLE B for 26.20(1): Write-in voting target not marked. The voter has written in the names on the write-in lines but has not marked the voting targets. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- Candidate 9
(Write-in vote, if any)
- Candidate 8
(Write-in vote, if any)

This example shows one vote for CANDIDATE 1 and one vote for CANDIDATE 2. Iowa Code section 49.99 requires voters to mark the voting target for write-in votes on special paper ballots or the votes do not count. These write-in votes have no effect.

EXAMPLE C for 26.20(1): Overvote. The voter has marked the write-in voting target, but has not written a name on the line. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- _____
(Write-in vote, if any)
- _____
(Write-in vote, if any)

This example shows an overvote. No votes shall be counted for this office. The voter’s choice here can be interpreted in more than one way.

EXAMPLE for 26.20(2): Two write-ins for the same person. The voter has written in the name of the same person on both write-in lines. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- Candidate 7
(Write-in vote, if any)
- Candidate 7
(Write-in vote, if any)

This example shows one vote for Candidate 7. Iowa Code section 49.99 provides that only one vote be counted if a voter writes the name of the same person more than once in the proper places on a ballot for an office to which more than one person is to be elected.

EXAMPLE for 26.20(3): Write-in vote duplicates other votes. The voter has written on the write-in lines the names of the candidates for whom the voter has also marked the voting targets next to the printed names. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- Candidate 1
(Write-in vote, if any)
- Candidate 2
(Write-in vote, if any)

This example shows a vote for CANDIDATE 1 and a vote for CANDIDATE 2. Although the write-in votes duplicate the votes for candidates on the ballot, it is clear that the voter has chosen CANDIDATE 1 and CANDIDATE 2.

EXAMPLE A for 26.20(4): Write-in vote for team on the ballot. The voter has written in the names of the candidates for president and vice president whose names also appear on the ballot.

For President and Vice President

(Vote for no more than one team.)

- CANDIDATE 19, of State
CANDIDATE 20, of State
Party A
- CANDIDATE 21, of State
CANDIDATE 22, of State
Party B
- CANDIDATE 23, of State
CANDIDATE 24, of State
Organization C
- CANDIDATE 25, of State
CANDIDATE 26, of State
Organization D
- Candidate 21
Write-in vote for President, if any
- Candidate 22
Write-in vote for Vice President, if any

This example shows a vote for the Party B team of Candidate 21 for president and for Candidate 22 for vice president. The voter has clearly chosen this team of candidates.

EXAMPLE B for 26.20(4): Identifying mark with write-in vote for team on the ballot. The voter has written in the names of the candidates for president and vice president whose names also appear on the ballot and has identified the political affiliation of the voter.

For President and Vice President

(Vote for no more than one team.)

CANDIDATE 19, of State
CANDIDATE 20, of State
Party A

CANDIDATE 21, of State
CANDIDATE 22, of State
Party B

CANDIDATE 23, of State
CANDIDATE 24, of State
Organization C

CANDIDATE 25, of State
CANDIDATE 26, of State
Organization D

Candidate 21
Write-in vote for President, if any *By the New*
Candidate 22 *Party*
Write-in vote for Vice President, if any

This is not a vote. The political identification next to the write-in lines is an identifying mark, as defined in rule 26.14(50). **Do not count any votes on this ballot pursuant to Iowa Code section 39A.4(1)“a”(6) or 49.92.** Follow the procedure in rule 26.14(50).

EXAMPLE C for 26.20(4): Write-in vote for part of a team. The voter has written in the name of the presidential candidate of one party and the vice presidential candidate of another.

For President and Vice President

(Vote for no more than one team.)

CANDIDATE 19, of State
CANDIDATE 20, of State
Party A

CANDIDATE 21, of State
CANDIDATE 22, of State
Party B

CANDIDATE 23, of State
CANDIDATE 24, of State
Organization C

CANDIDATE 25, of State
CANDIDATE 26, of State
Organization D

Candidate 19
Write-in vote for President, if any
Candidate 22
Write-in vote for Vice President, if any

This example shows a vote for the team of Candidate 19 for president and for Candidate 22 for vice president. This does not count as a vote for the president/vice president team of either Party A or Party B.

EXAMPLE D for 26.20(4): Write-in vote for part of a team. The voter has written in the name of the presidential candidate of one party and the name of another person for vice president.

For President and Vice President

(Vote for no more than one team.)

<input type="radio"/>	CANDIDATE 19, of State CANDIDATE 20, of State Party A
<input type="radio"/>	CANDIDATE 21, of State CANDIDATE 22, of State Party B
<input type="radio"/>	CANDIDATE 23, of State CANDIDATE 24, of State Organization C
<input type="radio"/>	CANDIDATE 25, of State CANDIDATE 26, of State Organization D
<input checked="" type="radio"/>	<u>Candidate 19</u> Write-in vote for President, if any
<input checked="" type="radio"/>	<u>Candidate 45</u> Write-in vote for Vice President, if any

This example shows a vote for the team of Candidate 19 for president (who is also the presidential candidate for Party A) and for Candidate 45 for vice president. This does not count as a vote for the president/vice president team of Party A.

EXAMPLE E for 26.20(4): Write-in vote for president and vice president. The voter has written in votes for president and vice president.

For President and Vice President
(Vote for no more than one team.)

<input type="radio"/>	CANDIDATE 19, of State CANDIDATE 20, of State Party A
<input type="radio"/>	CANDIDATE 21, of State CANDIDATE 22, of State Party B
<input type="radio"/>	CANDIDATE 23, of State CANDIDATE 24, of State Organization C
<input type="radio"/>	CANDIDATE 25, of State CANDIDATE 26, of State Organization D
<input checked="" type="radio"/>	<u>Candidate 44</u> Write-in vote for President, if any
<input checked="" type="radio"/>	<u>Candidate 45</u> Write-in vote for Vice President, if any

This example shows a vote for the team of Candidate 44 for president and for Candidate 45 for vice president.

EXAMPLE F for 26.20(4): Write-in vote for president and vice president. The voter has written in votes for president and vice president.

For President and Vice President
(Vote for no more than one team.)

- CANDIDATE 19, of State
CANDIDATE 20, of State
Party A
- CANDIDATE 21, of State
CANDIDATE 22, of State
Party B
- CANDIDATE 23, of State
CANDIDATE 24, of State
Organization C
- CANDIDATE 25, of State
CANDIDATE 26, of State
Organization D
- Candidate 44
Write-in vote for President, if any
- Candidate 50
Write-in vote for Vice President, if any

This example shows a vote for the team of Candidate 44 for president and for Candidate 50 for vice president. Even though other write-in votes have been counted for Candidate 44 for president with a different vice presidential teammate, this team is listed and counted separately.
[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—26.21(49) Corrections by voter. A vote for an office or question shall be counted if the voter has marked the ballot in a manner that will be counted as an overvote by automatic tabulating equipment but the voter has indicated in a clear fashion that the voter has made a mistake. The correction shall be honored if the correction does not include an identifying mark in violation of Iowa Code section 39A.4(1)“a”(6) or 49.92.

EXAMPLE A: Correction. The voter has crossed out the mark for one candidate and has written in the names of two persons on the write-in lines. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)

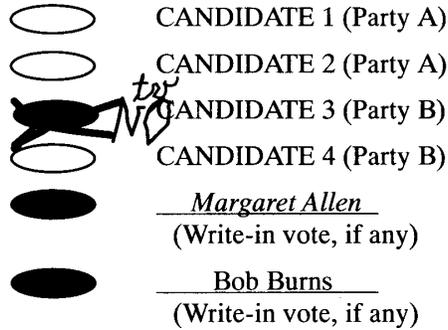
- CANDIDATE 1 (Party A)
- CANDIDATE 2 (Party A)
- CANDIDATE 3 (Party B)
- CANDIDATE 4 (Party B)
- Margaret Allen
(Write-in vote, if any)
- Bob Burns
(Write-in vote, if any)

This example shows a vote for Margaret Allen and a vote for Bob Burns. The voter has clearly crossed out the mark for CANDIDATE 3.

EXAMPLE B: Identifying mark. The voter has corrected a mistake by crossing out a marked voting target and has also initialed the correction.

For Board of Supervisors

(Vote for no more than two.)

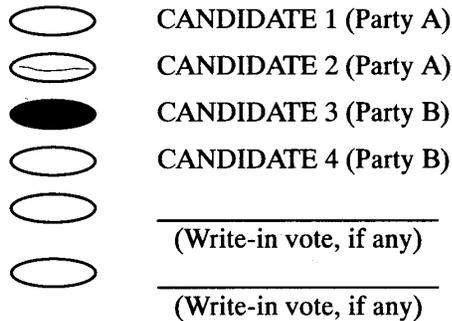


This example does not show a vote. The initials next to the correction identify the voter. **Do not count any votes on this ballot pursuant to Iowa Code section 39A.4(1)“a”(6) or 49.92.** Follow the procedure in rule 26.14(50).

EXAMPLE C: Erasure. The voter has attempted to erase one marked voting target and has marked another voting target. Two persons are to be elected to the county board of supervisors.

For Board of Supervisors

(Vote for no more than two.)



This example shows a vote for CANDIDATE 3. The voter has attempted to erase the mark for CANDIDATE 2. Count this as a vote for CANDIDATE 3.

721—26.22 to 26.49 Reserved.

PART III—PAPER BALLOTS

721—26.50(49) Standards. The precinct election officials shall count paper ballots according to the standards for optical scan ballots with the exception that write-in votes shall be counted according to the standards in 26.51(49).

721—26.51(49) Write-in votes. The precinct election officials shall count write-in votes on paper ballots without regard to whether the voter has made a mark opposite the candidate’s name.

721—26.52 to 26.59 Reserved.

PART IV—VOTING MACHINES

721—26.60(49) Abandoned ballots. Rescinded IAB 4/20/11, effective 5/25/11.

721—26.61(49) Counting emergency paper ballots. Rescinded IAB 4/20/11, effective 5/25/11.

721—26.62(52) Write-in votes on certain voting machines. Rescinded IAB 8/1/07, effective 7/13/07.

721—26.63 to 26.99 Reserved.

PART V—RECOUNTS

721—26.100(50) Requester. Any person who received votes for an office, including the person who received the most votes, may request a recount. If a person who is an apparent winner of an election requests a recount, the person who received the next highest number of votes for that office shall assume the functions of the “apparent winner” as designated in Iowa Code section 50.48. These functions include:

1. Receiving notice of the recount.
2. Designating a member of the recount board.
3. Calculation of bond.

721—26.101(50) Recounts for candidates who run as a team. For the offices of president and vice president of the United States, and for governor and lieutenant governor, either of the two candidates may sign a request for a recount or designate a member of the recount board.

721—26.102(50) Bond. In an election for a jurisdiction that includes more than one county, only one bond is required for each candidate who requests a recount for that office. For state and federal offices, the bond shall be filed with the state commissioner of elections. For other elections, the bond shall be filed with the commissioner responsible for the election under Iowa Code section 47.2(2). If more than one candidate for a multicounty office requests a recount, the bond requirement shall be calculated for each candidate.

721—26.103(50) Recount board. A three-person board shall conduct the recount.

26.103(1) The person requesting the recount shall name one board member in the written request. If more than one person files a request for a recount of the same office in the same county, the board member shall be the designee of the first person who filed.

26.103(2) The apparent winner shall name one board member at or before the time the board is required to convene. If more than one person is to be elected to the office in question, the designation shall be made by the apparent winner who received the fewest votes.

26.103(3) The board members designated pursuant to subrules 26.103(1) and 26.103(2) shall mutually agree upon the third member of the board.

721—26.104(50) Responsibilities of the recount board. Recount boards do not resolve procedural or legal questions about the conduct of the election or the qualifications of voters. The responsibility of a recount board is to tabulate all votes for the office in question on ballots that were counted by the precinct election officials at the election.

26.104(1) Ballots to be recounted. All ballots that were accepted for counting shall be recounted.

a. This includes disputed ballots returned separately pursuant to Iowa Code section 50.5.

b. This does not include spoiled ballots.

c. This does not include absentee or provisional ballots that were rejected before the ballot envelope was opened.

26.104(2) Ballot packages. The recount board shall open only the sealed ballot containers from the precincts specified in the request to be recounted or from the precincts specified by the recount board. Ballots from precincts that are not included in the recount shall be kept sealed or kept separate from those being recounted.

26.104(3) Standards. A voter’s definite choices shall be counted even if the recount board determines that the voter’s choices differ from the votes as counted by the tabulating device. The recount board shall follow the standards for counting votes as prescribed by Iowa Code sections 49.92 to 49.99 and this chapter.

26.104(4) Sealing ballot packages. When the recount is completed, the ballots must be sealed in the same manner that ballots are required to be sealed on election night. The envelope or container must

have across its opening a seal that is signed by all members of the recount board. The seal shall be applied so that the ballot package cannot be opened without breaking the seal.

[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—26.105(50) Duties of commissioner and commissioner’s staff.

26.105(1) *Ballot security.* The county commissioner (or the commissioner’s designee) shall be responsible for the security of the ballots and shall supervise their handling. The commissioner shall ensure that the ballots are protected from alteration, damage or loss.

26.105(2) *Optical scan tabulation duties.* In counties with electronically tabulated optical scan ballots, the recount board may request that the ballots be recounted by machine, may count the ballots by hand, or may do both. The county commissioner or members of the commissioner’s staff shall operate the tabulation equipment for machine recounts. The same program used on election day shall be used in the recount unless the program is believed or known to be flawed.

[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—26.106(50) Access to meeting. Recounts, like all canvasses of votes, are open to the public. However, observers may not participate in the recount. Because a recount is a purely ministerial function, rather than a policy-making one, recounts are not subject to the notification requirements of the Iowa open meetings law. (See Iowa Code section 21.2 for the definition of “meeting.”)

721—26.107(50) Report of the recount board. The report of the recount board shall be filed with the county commissioner no later than 18 days after the board of supervisor’s canvass of the votes for the election in question or 11 days after city primary elections or the regular city election in cities with runoff election provisions.

These rules are intended to implement Iowa Code section 49.98 as amended by 2004 Iowa Acts, Senate File 2269, section 21.

[Filed 8/27/04, Notice 7/21/04—published 9/15/04, effective 10/20/04]

[Filed emergency 10/12/04—published 11/10/04, effective 10/20/04]

[Filed emergency 10/4/06 after Notice 8/30/06—published 10/25/06, effective 10/4/06]

[Filed emergency 7/13/07—published 8/1/07, effective 7/13/07]

[Filed ARC 9468B (Notice ARC 9292B, IAB 12/29/10), IAB 4/20/11, effective 5/25/11]

CHAPTER 11
INJURED VETERANS GRANT PROGRAM

2006-2007 PROGRAM GUIDELINES

801—11.1(35A) Purpose. The purpose and legislative intent of this program are to provide immediate financial assistance to an injured veteran during recovery and rehabilitation from an injury or illness received in the line of duty in a combat zone or in a designated hostile fire zone after September 11, 2001.

801—11.2(35A) Grant amounts. 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.
\$2,500	30 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration.
\$2,500	60 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration.
\$2,500	90 days after evacuation date if still hospitalized, receiving medical treatment or rehabilitation services by the military or Veterans Administration.

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 an injury or illness in a combat zone or hostile fire zone; and

b. The injury or illness was serious enough to require medical evacuation from the combat zone to a military hospital or the injury or illness required at least 30 consecutive days of hospitalization at a military hospital; and

c. The injury or illness was or is considered by the military to have been received in the line of duty, based upon the circumstances known at the time of evacuation, injury or illness.

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]

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.
- (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)242-5331 or (800)838-4692 or by fax (515)242-5659.

11.4(2) *Process for present and future injured veterans.*

a. The department will establish contact with the appropriate level of command or the casualty assistance office of each military service component to develop a combat casualty tracking system. (For example, the adjutant general of Iowa serves as the command authority for providing the department with accurate data to track all combat injured veterans assigned to the Iowa national guard.)

b. When the department receives an official casualty notification from a designated service office that a veteran has been medically evacuated from a combat zone, the department will assign a case manager to serve as a point of contact for the next of kin designated on the veteran's DD93. The case manager will, within 48 hours, 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 was injured while serving in that national guard unit and is not eligible to receive a similar grant from another state for that injury and provide the department with the required data to disburse the first grant payment. The check will be made payable to the veteran and mailed or presented to the next of kin. The case manager will then maintain weekly contact with the service component and the next of kin to track the treatment progress of the veteran and ensure that subsequent grant payments are disbursed in a timely manner.

c. Grant payments will be stopped if the veteran is returned to duty or when medical or rehabilitative treatment is discontinued.

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]

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.

[Filed emergency 6/7/06—published 7/5/06, effective 6/7/06]

[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]

[Filed Emergency ARC 9471B, IAB 4/20/11, effective 3/31/11]